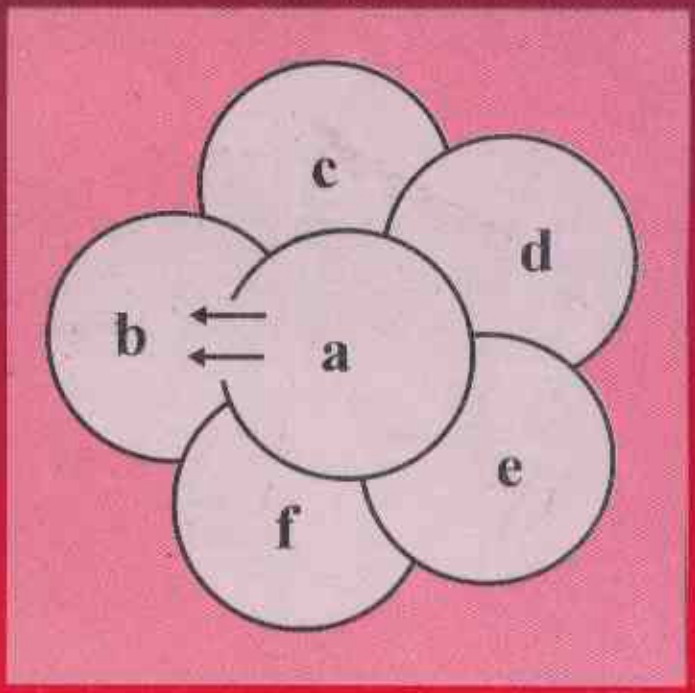
PSYCHOANALYTIC GROUP PSYCHOTHERAPY

SHAKUNTALA DUBE



The Book

This pioneering book covers a wide spectrum of issues to Psychoanalytically oriented Group therapy. The context of doctor-patient relationship in the traditionally rooted yet rapidly developing India, needs an innovative model of group therapy, especially when group therapy being held in a mixed group of males and females, or psychiatric patients of various categories and level of psychosocial functioning, or in a closed vs. open group, or when psychotherapy combined with Individual and Group, or fees being charged or not for this type of treatment given to the clients.

The book offers useful guidelines based on empirical findings collected over three decades in terms of summary documentation of Group-processes, illustrative case material and recommendations on what factors facilitated or impeded the Psychoanalytically oriented group-therapy.

The book has been written with wide readership in mind of mental health workers like Psychiatrists, Clinical Psychologists, Psychiatric, Social Workers as well as trainees and laymen who wish to know and learn group-therapy based on Psychoanalytic theory and technique.

The Author

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She has contributed chapters in various professional text books and also written a book "A Text book of Psychoanalytically oriented Psychotherapy-theory and technique", published under Core-Medical text book programme of National Book Trust of India. She has to her credit several published scientific papers and lectures delivered at various parts of the country and abroad.

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PSYCHOANALYTIC GROUP PSYCHOTHERAPY

Shakuntala Dube

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FOREWORD

This book has ably fulfilled the objective of how psychonalytically oriented group therapy can be successfully implemented in Indian setting. It presents in a comprehensive way the theory and techniques essential for practicing such therapies in the current mental health scenario in India.

The information in the book is set out in three chapters (1) perspective on the technique (2) methodological considerations and (3) results of therapy including case studies and recommendations for future research. It has clearly brought out the theory, basic concepts and principles of psychoanalysis in the traditional as well as the changed context of doctor-patient relationship and has tried to clear many of the misconceptions about such therapies. The author of the report who has a large number of years of experience in practicing psychoanalytically oriented group psychotherapy and has trained students, has given a realisic picture of what constitutes success and when the therapeutic failures occur; what factors facilitate or impede therapeutic progress; the role and characteristics of group therapists; on which types of clientele such group therapies can be instituted; the advantages of combining individual and group therapies; the use of open and closed groups; the techniques that can be usefully employed in the different phases of therapy such as in the initial phase, mature phase and in the terminal phase of therapy. The group processes that take place in group psychotherapy and the factors that affect group psychotherapy are well demonstraed by the case studies and the behavior of the group members - both patients and therapists.

This book will provide very useful and practical knowledge to students and practitioners in mental health field.

since no such documentation on psychoanalytically oriented group psychotherapy in India is available.

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The Indian Council of Social Science Research provided financial support to me under the grant of documentation and publication of Group Therapy programme which I had carried out at the Department of Psychiatry, All India Institute of Medical Sciences between September 1971 and February, 1995. Many helped me in this preparation : these include Dr. D. Mohan, Head of Department of Psychiatry, Dr. L. M. Nath, Ex-Director-cum-Dean, All India Institute of Medical Sciences, New Delhi. They provided me with valuable encouragement and inputs after my retirement from service. Several other ex-colleagues from the hospital staff, research associates, faculty members, psychiatry residents have been extraordinarily cooperative while running the group therapy and its research work and to these I am especially thankful. My ex-seretary Mrs. N. Gangadharan struggled with me in preparation of the manuscript.

Most of all I am deeply indebted to my teachers, parents, extended family members, some of them are no more in this world. But they had stimulated, supported, educated me and became models for me of professional growth and personal integrety. In ancient India there was sacred Guru-shishya relationship as sanskrit shloka says : "Guru Brahma, Guru Vishnu, Guru Devo Maheshwarah, Guru Sak-shat Param Brahma, Tasmai Shri Gurave namah". My humble tributes to guru : Late Raj Narain, Dr. H. S. Asthana, and teachers of Department of Psychology, Lucknow University and at the NIMHANS Bangalore, Personal-analyst Late Abram Kardiner, Group Therapist Late Asya Kadis and her co-therapists, as well as my supervisors at the Post Graduate Centre for Mental Health, New York.

Lastly, I owe gratitude to all my patients, group member-students, and co-therapists who participated and contributed in the group therapy, without their contribution this report would not have been submitted.

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Chapter 1

Perspective on the Technique

Introduction

In a group individuals act differently than when they are in isolation or when they are not under the influence of other members. However, a holistic approach to mental health problems requires that we do not view the individual as an isolate but as a member of the family and/or wider social group. The tendency to form groups has been viewed as a continuation of multicellular characteristics of all higher organisms. The groups are social system and they have the capacity for restructuring themselves by means of self-corrections within their larger social environment assesment of large information from their surroundings. Although it is now generally accepted that any small group including psychotherapy group, can be described in terms of its characteristics as a social system; this was not so till 1940's when appropriate research technique to explore group dynamics became available.

The pioneer work by K. Lewin (1947, 1951) , S.E. Asch (1951) and others in this direction established a methodology for controlled observation of groups and an experimental manipulation of group variables like group structure and pressure, leadership, cohesive and destructive forces, role distribution etc. became incresigly possible. Small face-to-face groups could be described in terms of properties belonging to the group as a whole. Many diverse phenomena could be understood when the group was conceptualised as a social system that comprised of elements having a lawful

relationship to one another. Such total group characteristics have been shown to have an important impact on the behaviour of individual members. Social psychologists, no longer talk about 'group mind' or 'group unconscious' but instead stress the importance of group goals, atmosphere, sociometric structure, communication pattern etc. These are viewed as properties of the group as a whole which derived themselves from the interaction of the members of group with one another in somewhat predictable and orderly manner within the wider social framework.

Theoretical framework

A number of therapeutic approaches and techniques as well as theories based upon the diversity, complexity and fluidity of group processes which reflect the fundamental natural relationships between the individual and his social context have been developed by the group therapists. The literature on group therapy brings out a wide range of theoritical postulations on therapy group as a social system. According to one theoritical standpoint, "although therapy groups may be described in terms of the dynamics of the group, 'group dynamics' are detrimental to the therapeutic aim" (Slavson, 1957). Wolf and Schwartz (1962) advocated that attention to group level processes in therapy group is likely to defeat the therapeutic goal; they regard group processes as inherently destructive to the individual. Durkin (1957) and Locke (1961) have suggested that although forces exist, which may be described as belonging to the group as a whole, they tend to be irrelevant to the therapeutic work of the group. In sharp contrast to these positions are the views put forth by Foulkes (1957) Bion (1961) Bach (1954) Ezriel (1950) Frank (1957) Whitaker and Lieberman (1964). Although they differ in many respects, they share the common view that group processes are central to the

therapeutic processes. Yalom (1970) seems to take a middle position; he has advocated that :

> most important of all, is that through a total group focus, the therapist avoids the pitfall of engaging in individual therapy with any of the group members. This danger is more apparent than real however, if the therapist has the mobility and flexibility of role which will enable him to deal with issues of favouritism and rivalry as they arise (page 140).

The stand which one may take on general issues of current practices in group psychotherapy requires some empirical data to be gathered by group therapists to be able to make scientific assumptions about the nature of psychiatric illnesses and technique of treatment, to be applied . It is not desirable to make an exclusive choice between psychoanalytic and the group dynamic explanations; but firstly to pay attention to : whether and in what manner the group processes are relevant to the therapeutic progress of the individual patient. It is necessary that not only the overt events but also the covert aspects of the social context are carefully analysed. It is not only the manifest behaviour of the patients but also his unconscious underlying motives, defense mechanisms and coping strategies which needs to be inferred from how he participated in, contributed to and reacted to group forces that determined his therapeutic experiences. Secondly what was the role of the therapist, her position with reference to the group forces and the manner in which she might have influenced as well as utilized them for the benefit of each patient (henceforth the group therapist will be addressed in the feminine -voice but it will be applicable to male therapist as well, similarly patient in the male voice will be applicable to female patient's as well).

The Group Therapeutic Process:

In addition to the cognitive and rational aspects like imparting of information, role modeling, imitative behaviour, assertive training in socialization, interpersonal learning etc. equal attention is to be paid to the emotional and even irrational and impulsive aspects (like unconscious wishes, urges, conscious wishes and urges, instilling hope, promoting group cohesiveness, altruism, universality etc.) and providing a setting for 'corrective emotional experience', (by catharsis or corrective recapitulation of the past memories of the primary family group with exploration of transference relationship in 'here and now' situation), after resolving the patient's resistances by focussing group's attention upon either (1) the interaction between group members or group's avoidance to the primary task; (2) the way of directing the group from non-relevant to the relevant or from 'then- and there' to 'here-and-now' material. (3) 'acting out' to 'acting in' of impulsive behaviour to be encouraged and followed by developing insight and proper judgement in handling the poor impulse-control or any such maladaptive behaviour.

Psychoanalytic Group therapist's role

No matter, how carefully the therapist selects her patients, composes the group and establishes the well laid down therapeutic norms, only working experience with the group members enables one to find out what determined the group to develop constructively in terms of therapeutic effectiveness in the long run to its members. There are certain kinds of group interactions or solutions viewed by group therapists as beneficial while others as damaging. The interactions like scapegoating, displacement, turn-taking, pairing (emotional closeness between two members resulting in secret talks, flight or fight together and so on) are therapeutically undesirable, and group solutions which allow for free and open expression

of feelings thoughts, fantasies or dreams are regarded as beneficial. Research evidence documenting the importance of group therapeutic processes is rudimentary compared to the individual psychotherapy research even in the West. Nevertheless, the relevant studies have indicated that in the group therapy adherence to (1) acceptance of the patient's role (2) self-disclosure, (3) honesty about feelings toward oneself and other members (4) non-defensiveness (5) Interest in and acceptance of others (6) support of the group (7) Personal improvement are rewarded by the group; These have been viewed as important (Yalom, 1970), probably because the patient-group acts therapeutically in two ways- by influencing self-esteem in individual member and by reinforcing adaptive social skills.

There is lack of published research evidence on group therapy in the psychiatric setting of India, but one can assume that psychotherapy groups are relatively unstructured groups. In the initial stage, the members are patients who have come to an expert authority of mental health seeking personal help of the kind which requires examination of their cognitive knowledge, attitude as well as unaware or forgotten or repressed material. The effective therapist generates a specific type of therapeutic -relationship with her patients (by way of first taking them for individual therapy or by carrying out a few depth-interviews) and therefore, it has become an established practice that the quality of this relationship is independent of the individual therapist's school of conviction (Fieldler, 1950, 1951). In fact the patients join the group at the behest of the therapist and view the therapist as one who knows what mental health is all about and how the group therapy may bring it about. Individual member care little and rather have little insight about the aims of the therapists and other group members. However a blind acceptance or rejection of the authority of the therapist as a mental

health specialist and greater intimacy and understanding of members' aims or mistrust hamper effective interpersonal learning. As New Comb* (1947) and other group therapists have shown the unexpressed mistrust or autistic hostility (when another group member is viewed as a threat) moves regularly from preoccupation with authority to preoccupation with personal relations. This is evident from three phases in which the group moves, and has been described as (1) submissiveness (2) rebellion (self-identity) (3) independence. The group is a social system, conflicts are a series of polarizations which the members encounter and convert into a paradox which require then to be handled by the group and the leader. In this context Freud's view point require to be stated.

Freud (1913, 1921) had attempted to analyze human groups. According to his view point, individuals feel power by being together and they unloose repressions and the unconscious personality predominates in the crowd; The 'id' impulses are to express themselves. The individual feels safety in expressing his id impulses because the group supports him in this activity. In a group, every sentiment and act of every individual is contagious and has been classified among the phenomena of a 'hypnotic -order'. Suggestibility is another characteristic of individual in a group viz. The tendency to transform readily ideas into action. Freud used the term 'libido' (the energy of the sexual instinct in a wider sense) instead of contagion or suggestion to designate the 'power' or 'force' that holds individuals in a group together. Each

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* New Comb States that unexpressed or autistic anxiety arising when another is viewed as a threat. It is likely to persist until modified by further interaction. If as a result of a hostile attitude communication with other person is avoided, the conditions necessary for eliminating of the hostile attitude are not likely to occur. At the most fundamental level one simply does not enjoy contact with some one he dislikes, the resulting lack of communication bars the opportunity for attitude change.

group member is an 'object' upon which the other group members organise 'cathaxis'. The members of the group are bound by libidinal-ties to the leader and on the other hand they are bound by similar ties to the members of the group. Ordinarily, men feel aversion and hostility to strangers but in a group they repress their hostility and tolerate one other. Because of their repressed hostility (group members respect force, not reason) object-relations among members are "Propped-up" and intensification of emotions among members is a characteristic of such a group. The greater the number of people in whom the same emotion can be stimulated, the stronger does the automatic compulsion grow to give-in and to have no mind of 'one's own'. Freud referred to these kinds of relationships as conflicts derived from stages of psychosexual development which interfere with the development of object relations. The problems with authority are conflicts which arise in the preoedipal stages', while those of intimacy with peers derive from oedipal problems which must be resolved before successful 'pairing' can take place. The concept of 'pairing and intimacy is broader than sexual relationships but must include them.

One may or may not adhere to Freudian views on 'group'. But all groups, structured or unstructured at the beginning are an undifferentiated entity (holistic concept) which at any given time has a location in an environment : the goal may be defined as a preferred location for the group toward which it may move or locomote. In order for the group to change its location towards a set goal, it is necessary for it to perform a sequence of group activities. The Western research findings on group dynamics (which are relevant for psychoanalytic psychotherapy) suggest that there are three levels of group operations (Thelen, 1954) 1. total group operation 2.. relation of individual to the group process 3. relation of sub-groups to group process. The concept of a group as

a system with characteristic properties is more valuable than to anthropomorphize the group with vague concepts like 'group- ego' or 'group superego' or 'group mind' as if it were a living entity, expressing itself in different ways through various members.

Bion (with Kleinan orientation of Melanie Klein Object - relation theory practiced in U.K.) studied the nature of group phenomena. He noted that at times the group appeared pursuing the 'primary -task' in a rational effective fashion, which he called as 'work - group' or 'culture'. At other times the group no longer seemed pursuing its primary task. It appeared to be dominated by certain massive emotional states which resulted in behaviour in- compatible with primary task. Three types of basic, recurring emotional states have been suggested: 1. aggressiveness, hostility and fear 2. optimism and hopeful anticipation 3. helplessness and awe. Bion (1959) proposed basic dynamics for of all groups. Later group workers were unable to classify similarly shaping events in their own groups. As Yalom (1970) stated : "Bion it must be remembered studied group phenomena in a highly specialized type of group. Although Bion's direct influence on the practice of group therapy is limited, his indirect influence may have been considerable. His method of viewing the group as a whole, his focus on the here and now, his attempt to understand unconscious forces influencing group texture and activity were indeed innovative" (page 136). Ezriel (1950, 1952) a participating observer of Bion's early groups have viewed group phenomena differently. He directed his attention to therapist-patient relationship and noted that the patient is required to relate (the required relationship) to the therapist in one fashion in order to avoid occurrence of a second type of relationship (the avoided relationship). The patient unconsciously attempts to avoid the second type of relationship because his unconscious fantasies make him be-

lieve that if it were to emerge into reality, a third type of relationship -some dreaded calamity would occur. According to this view point recognition of these relationships (required, avoided and calamitous) is essential for the understanding of the dynamics of both individual and group therapy sessions. For the group, he adds two concepts viz the 'common group-tension' and 'common group-structure'. The aim of both individual and group therapy is thought to be removal of unconscious conflicts and sources of unfulfilled needs reflected into transference. The therapist is viewed 'nothing but a passive projection screen' except for her active steps of interpretation. Because the essence of the psychoanalytic therapeutic process is the 'reality testing' which is induced by-interpretations. This approach not only restricts the therapist's role but the group too may become restricted. Especially for those therapists who are not orthodox. Non-Freudians, find the psychoanalytic terminology of interpretation unacceptable. Moreover, the maladaptive interpersonal relationship of patients in the group are compelled by internal reasons or current psychopathological state this they relate to others in a distorted style of relationships exhibited in terms of rejection, scorn, engulfment, interacting with others by uncontrollable rage etc. They require the therapeutic setting of safety in which they feel like expressing themselves and can lower their defenses. The therapist should establish the 'analytic setting' in which each member can feel safe to interact intensively. Unless the therapist herself is 'transparent' (allows her feelings and thoughts to be shared in a frank, honest and relaxed manner) and empathtic and trusts members to come up with their own direction - as if they are the' best - knowers' of themselves and she can keep a low - profile of herself as the therapist, members' self-discloser is not feasible in group therapy.

For establishing and maintaining the 'group-culture'

(defined as the body of solutions on which the group keeps operating) the therapist has several tasks to perform viz.

1. To establish group solutions (which are viewed beneficial and avoid those which can damage cohesiveness in the group) by way of working with members and keeping them interacting in the group.

2. To establish and maintain conditions of safety in the group so that individual members feel free to take risks and expose themselves in the overall setting of doctor-patient relationship.

3. To manage and gear group processes* for the benefit of the individual patients; for this the therapist keeps an open eye on the position of various patients vis-a-vis the group forces.

The therapist should be alert to evaluate 'how' and 'why' of the verbal interactions, especially in so far as the 'how' and 'why' illuminates, the patient's relationship to others with whom he is interacting, whether it can be beneficial or harmful and the correct 'timing' when the group forces can provide for intervention or insightful interpretation. The therapist considers the 'meta-communication' (the nature of the relationship between the two interacting individuals and their communication message) in terms of why the patient is making this statement at this time, to this person in this manner? In group therapy, the focus of the therapist is on the process as well as on clinical understanding of the individual's psychodynamics and psychopathology.

A 'here and now' or a 'historical approach' to therapy focusses on what is happening in the group in the present at

* The term 'process' is being used liberally throughout this text. It has a highly specialised connotation in other fields like Anatomy, Sociology, Psychoanalysis etc. In group psychotherapy 'process' refers to the ongoing nature of interpersonal relationships.

this very moment. There is decreased emphasis on the patient's historical past or in the details of his current life problems. The more salient data required and gathered by the therapist which in fact the group forces provide for interpretation are inferred through the immediate patterns of interpersonal interactions in the group. The interpersonal behaviour (verbal as well as non-verbal) in the group of each patient is assumed to be an accurate interpretation of his interpersonal behaviour outside the group.

4. The therapist (instead of analysing the problems of one patient at a time) has to create optimal conditions for involving all the members in the group for therapeutic work. Since each individual in the group is likely to take a unique stand with reference to the group-solutions or conflicts as well as his own anxiety, defenses and coping style posing problem of resistance, this causes trouble in the group. These interfering forces require skilful understanding by noting down, when smooth interaction between them as well as communication is necessary to solve problems or to see if a 'focal group' conflict is taking place.* It gets reflected when the group process is getting blocked. It is the therapists task to facilitate group acceptance. She is able to provide this by personal integrity, love, dependability, trust and above all skillful professionalism.

There is a mass of accumulated research evidence in the West to show that an individual is helped in the group therapy as a resultant recipient of the interplay of several factors like his interpersonal needs, his strength and weak-

* It is due to shared concern among members about style of functioning of the therapist or underlying uneasiness about having been placed in group therapy or any such shared feelings among them. This is inferred not only in content of talk but also non verbal behaviour, mood, pace, sequence etc of talk.

nesses, his extra group resources, and the composition and culture of his particular therapy group. According to Yalom (1970) "Although these issues require considerable research, certain conclusions seem heavily supported by all available studies. Group therapy draws its unique potency from its interpersonal and group properties. The agent of change appears to be the group and its intermembers influence net - work. The effective group therapist must direct his efforts toward maximal development of these therapeutic resources"(page 81).

If we accept the Lewinian theory of the group as a dynamic unity of interdependent parts, it is not difficult to take the next logical step of viewing each part (member) as having feed-back capacity. For other members as well as the whole group the total feed-back may then be seen as a stabilizing mechanism for the whole. In this sense all groups have been considered as homeostatic systems. The kind and direction of change that occurs in each could depend upon the purpose for which it was formed and the skill of the leader.

Rogers' (1970) eight hypotheses regarding group members' variables are common to most groups. The therapeutic group may thus be considered to have a capacity for self-correction of the members' distortion by means of group feed-back. Both interpersonal and communications theorists view the human being and the group primarily as self-correcting and self-regulating systems. However, that the psychoanalytic theorists view (especially classical Freudian) the tie that holds the members of group together is of a libidinal nature. It is derived from the members' libidinal but aim-inhibited drives toward the leader and their mental identification through the common tie. According to them - 'Object-relations' among the members are 'propped up' upon earlier now archaic - identification which is potentially am-

bivalent and can turn either to 'love or hate'.

This psychoanalytic view holds that in a group hate is usually repressed by way of the member's substitution of his 'ego-ideal' for that of the leader. Thus members tolerate one another's differences and idiosyncracies, forgiving faults etc. Freud felt that such a limitation of "narcissism" could come about only by way of a libidinal tie. As has been stated earlier, Freud accepted that emotional intensity is heightened and intellectual activity is decreased in members, and that even members of better organized groups endow their leader with extraordinary prestige and evidence a high degree of suggestibility.

These days our public sector organisations and large management circles often complain that it takes decades to get people, (at least a sizeable numbers) to take initiative, to learn and to change. Similarly, on the surface, in the therapy - groups passive - dependence is apparent in behaviour of several members who attempt to ward-off their anxiety by clinging to the therapist like a child. If the therapist maintains complete silence as a passive observer and allows lack of clarity to develop and maintain silence about 'who is who' and what is to be the group-task, then the group process is likely to end up into projective distortions and confusion. The process might then shift from seeking help from the protective leader to the need for some form of a structured, or search for a common goal. The real anxiety (as evident by manifest behavioural sighs of restlessness among members, sub-grouping or pairing, scape-goating, violation of norms, etc.) concerns their feelings towards the therapist who is seen as 'omnipotent authority'. The subsequent sessions are led by less dependent members or those who begin to rebel against the leader. They may or may not openly criticize the therapist but atmosphere of the group is one of frustration, disappointment hostility, suspicion of the leader's motives.

In psychoanalytic literature, such issues of patients' resistance and the effective ways of handling them have been well documented. However, in the initial phase, resistance which is on the surface may look like members' lack of introspective ability or psychological-sophistication are related to psychosocial variables (Dube 1981, 1983, 1997) It springs largely from lack of confidence in the therapist. It requires that the basic tenets of the therapeutic process must be the responsibility of the leader.

A deliberate effort in the initial stage of psychotherapy is therefore required on the part of the therapist to assume several roles to help the patient/group members. Apart from being an empathtic -psychotherapist with deeper commitment to provide help to patients, she has to be active, passive, spontaneous, encouraging as well as discouraging regarding 'what to talk about and what not to talk about at a great length.' The therapist has to be sensitive as well as scientifically well informed about psychopathology of the various mental states, defensive strategies that are adopted by various patients while experiencing emotionally overwhelming material coming to their surface of consciousness with high expectations e.g. role of a doctor in the Indian society that the therapist should understand their pain and do something about it quickly. In the group setting, for an example, the hysterical patients with their hearts brimmiging with traumatic childhood memories show great capacity to talk smoothly out soon become the center of attraction as well as of victimization of ridicule by group members.

The different individuals in the group are known to represent different 'family- images' simultaneously e.g. the therapist might represent an idealized mother, while a group member represents the bad depriving mother. The 'fear' which a patient experience immediately in the group, is of a reawakening of the past narcissistic-hurts and fears. He

imagines that the group members will be critical and demanding and that they will render him defenseless and helpless. According to Durkin (1964) the group cannot solve problems of love and intimacy until they can handle problems of power and status. In the initial stage, the patient does not take over the leader in place of his own ego-ideal; rather a complicated transference process sets in motion. The psychoanalytic therapists view that transference phenomena occur regularly both inside and outside the analytic situation. This will occur inside the therapy session distorting the group members relationships with one another as well as with the therapist. Although patients converse on a conscious level, at the same time they give one another preconscious cues for setting up interacting neurotic patterns of behaviour which could be warded off; yet secretly they express their unconscious infantile behaviour in a disguised form. The therapist has the advantage of observing at first hand a great variety of interpersonal behavioural pattern of patients. Such 'acting in' of the transference phenomenon can be analyzed through encouraging the patients to fully participate in the group interaction, then while reporting the subjective emotional reactions reinforce one another to give vitality and immediacy to their transference reactions. In this process, other members usually become co-therapists. The problems centering around identity, autonomy, status, envy, infantile rage, sexual or aggressive impulses and their conflicts and neurotic- patterns of coping with them require to be worked out in the therapeutic process with the help of the therapist. Clinical experience seems to validate that often the therapist is viewed or substituded for and displaced with infantile experiences with the mother. Thus the role of the therapist is to set-up the atmosphere which will be conducive to free and candid emotional interactions which in clinical parlence is called 'corrective emotional experience'. This provides patients the basic idea about the unfolding of therapist's relationship with them.

Therapist directly ask if any member wishes to bring up a specific problem or talk about problems which comes to his mind. She may, ask what brought the member to the therapy and why today? Similarly, the later sessions are also focussed on therapist's comments made on late coming, cancellation of an appointment, or missing any member, slip of tongue/speech, prolong silence maintained in the group, or picking up non-verbal cues of interactions among members which may involve all members in the group to express their opinion. For example each patient asked to give his ideas or free association on the subject matter like dream, symptoms, drug treatment, family tension or a subject matter of concern talked again and again by any other member in the group. Non-verbal cues like sitting arrangement if seen being rigidly followed , or passivity on the part of a silent member evoking feelings in other members etc. are picked up by the therapist to generate involvement of the members. Similarly the therapist should provide opportunity to members to ventilate their feelings and attitude towards the leader by giving them an open-session (without the presence the therapist). She also keeps aloof at times from the group interactions and allows self-correction by members of her distortion by means of group feed-back system and validation. While allowing problem solving discussion among members, she may give her direct advices or suggestions. But the therapist participates in group discussion like any other member of the group and in their decision making process she never acts like an expert authority so that the group becomes primarily a self-correcting and self-regulating system.

The psychoanalytic technique is to make the members first conscious about the latent repressed message or content. This is by way of listening to them with empathy, giving no advice, without giving out any value judgement, opinions etc. The group dynamics that constitute the therapeutic path-

ways are group process which are triggered by interaction, setting up norms, standards and values, pressure of group members on each other to conform to the set out standards, to leadership, scapegoating, performing which get evolved gradually by emerging group cohesiveness and validation. The group therapist requires some systematic and conceptual ideas concerning how to maintain yet keep a distance from this relationship. This training is provided to psychotherapists who receive advance formal training in group therapy and by observing regular ongoing sessions conducted by more experienced group therapists. This part of training curriculum is considered a valuable learning experience for the prospective group therapist* and provides the essential tool for the understanding of group dynamics in therapeutical sense.

Psychotherapy is both an art and science and thus it requires a dual orientation of clinical and research work. At present it is at crossroad of several controversies arising out of various approaches, notably of Gestaltist, Psychoanalysts, Cognitive - Behaviourist, Rational- Emotive, Client-Centered and Existentialist. Therefore, we should call this as 'group 'therapies' rather than group therapy. A survey of representative groups run in Northern California alone disclosed a wide variety of nearly two hundred types of groups (Yalom, 1970). These groups have not been confined to California

* The author received this valuable training at the Postgraduate Center for Mental Health, New York in the year 1969-71. She was in group - therapy treatment with Asya Kadis and subsequently with Marvin L Aronson. She observed groups led by famous experts like H. Durkin, H. T. Glatzer, E. Fried. She herself had carried out as co therapist with M. Markowitz couple-therapy which was videotaped and monitored by her supervisors sitting behind one-way mirror. Apart from Psychoanalytic groups, she also observed some of the groups conducted by Albert Ellis and others based on Rational - Emotive Therapy, Encounter groups based on Gestalt therapy and Psychodrama carried out in New York city in those days.

state alone : encounter groups, marathon group and nude week-end therapy groups, have been rising in numbers in U.S.A. Rogers (1968) called this intensive group experience movement as "one of the most rapidly growing social phenomena in the United States perhaps the most significant social invasion of the century".

In India too, Alcoholic- Anonymous, Drug-addiction Anonymous , Sensitivity - training , Transactional - analysis (T-groups) groups are being run without carrying out the necessary research in the basic principles involved and their treatment efficacy in our socio-cultural milieu. Even when group - therapy is led by a professionally trained therapist, the therapeutic task is indirect and influenced by the interactive process among uninitiated participants. This is more subtle and complex compared to what the therapist does in the individual psychotherapeutic environment. Although, a considerable part of work for running a long term group psychotherapy programme gets performed before the group starts. this maintenance-task (in terms of her therapists expertise in selection of proper members, their preparation for the treatment which greatly influences the fate of successful running any group and achievement of the ambitious goal by characterlogical changes of its members) is often lost sight of. A proper scientific scrutiny of various parameters is therefore required before group therapy is undertaken even by a trained therapist.

The list of the variables which the group-therapist can control include the size and the composition of the group, the physical setting, the frequency of the sessions, fees involved or otherwise, outside individual contacts (if any) the therapist provides for each member and her own participation in the group session. However, the therapeutic process which must provide the individual patient with the 'corrective-emotional experience' depends on the therapist herself as well

as on the subtle interactions among the group members. Thus the development of group cohesiveness, resolution of focal-conflict and other related variables of 'group processes' are generally beyond the direct control of the therapist.

Most of the social psychology research works on 'small groups' have little practical importance in group therapy since all the variables in group therapy cannot be manipulated in the therapeutic setting. While running the group therapy programme the therapist employs all the technical knowledge and skills at her disposal (which Liberman (1967) had defined 'therapist as social engineer'). Her intuitive understanding and clinical hunches about the direction of the group process at the specific moment (towards the curative factors or away from it), are of crucial importance. The therapist not only remains process-oriented and concerned with the verbal content of the patient talk, but also with the 'how' and 'why' of this manifest material and its latent message. Especially 'how', 'why', 'when', 'what' it can illuminate some aspects of the patient's relationship as well as to others with whom he is interacting (transference-issues) These are 'meta communicational aspects' of group psychotherapy which in our Indian social context require to be scientifically studied.

Many group therapists in the West have published their opinions about group therapeutic curative factors (Corsini and Rosenberg 1955) but after reviewing them Yalom 1977) writes "will reveal the range of curative factors but little about their comparative value. Moreover, it is possible that the various schools of convictions are not equally represented in the literatures." (Page 61).

The question is whether the curative factor described by therapists actually operate in the group or not ? There have been some interesting studies carried out on individual psychotherapy that can highlight this issue (Fiedler 1950,

1951, Feifel and Eells 1963, Blaine and McArthur 1958). They have demonstrated that although therapists of different disciplines may disagree cognitively about the curative processes in therapy, they resemble one another operationally. Further, a more important findings was that therapists and their patients have different views about the responsible curative factors in their therapy. The studies carried out on group therapy's curative factors (Berzon et al 1963, Talland and Clark 1954; Yalom et al 1970) have clearly demonstrated that not every one responds in the same way to the group therapy; there are many therapeutic path-ways in the group therapy. Most likely the manner in which an individual is helped is the resultant of the interplay of factors like his interpersonal needs, his assets and liabilities, his extra-group resources of social-support net-work , the composition and culture of his particular therapy group. The agent of change appears to be the group and the inter - members (including therapist) net -work. The effective therapist directs her efforts towards maximal developments of these therapeutic resources.

Critical Discussion

The analysis of group therapy sessions involves certain judgement about the meaning and relative importance of events in the session. Therefore the methodological difficulties inherent in making complex judgement about a multitude of overt events with reference to assumed latent meanings and their interpretations give rise to a pertinent scientific question; whether the basis on which these judgements are made can be explicitly defined and communicated ?. How far one can expect agreement among independent analyzers ? The innovative methodology of Bales (1950) 'interaction process analysis' and Leary's (1957) 'interpersonal reflex' are examples of molecular procedures but can they be applied to therapy groups?. The molecular approach lends itself to concise

definitions, reproductivity, and statistical treatment. But the findings of an holistic approach or global aspects of therapy groups are harder to defend and communicated in terms of established methods of statistical validity and reliability.

Chapter 2

Methodological Considerations

Objectives

The present documentation is aimed at describing those elements of group therapy sessions which might have made it possible to run open group* of psychoanalytically oriented psychotherapy for out -patient psychiatric patients for a long term. It was started at the department of Psychiatry, All India Institute of Medical Sciences, New Delhi by the investigator in the year 1971. This group therapy treatment programme continued uninterruptedly till her retirement in February, 1995. The goal of the therapy constituted a difficult task of bringing symptom-removals as well as characterological changes by 'insightful learning' and by providing 'corrective-emotional experience'. In addition, drug treatment (but no physical forms of treatment like E.C.T., Psychosurgery etc.) was provided to those psychiatric patients who came for out-patient psychiatric treatment and were found to be suitable for a long term group therapy programme.

In reporting the observations on the global aspects of the open -group* therapy, the investigator is required to describe her procedure (of psychoanalytically oriented groups psychotherapy) explicitly as far as possible.

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* At their inception groups are designated by their therapists as open or closed. An open - group maintains a consistent size by replacing members as they leave the group and the group continues indefinitely where as closed - group once begun closes up on due date, accepts no new members and meets for a predetermined number of sessions.

Also, why the group therapeutic process has been conceptualised in discrete stages namely, initial phase, middle phase and termination phase observations. In support of giving objective evidence, some findings have also been reported whenever attempts were made to bring independent observers in the open group therapy session as well as investigator's observations which were made on other groups' setting viz Department of Medicine on Obesity patients, and Normals who were mental health professionals or Medical undergraduate students of AIIMS. The closed groups were of a small size of 6 to 8 members, both males and females who were given short- term group psychotherapy of less than six weeks duration or a 'closed - group which ran only for three sessions of a larger size (of twelve professionals mainly in the field of mental health.)

It is difficult to guard against one's bias and judgement in this documentation which might have crept in, especially when from the start the therapist not had been in the present role of an investigator and her therapeutic process had been neither tape-recorded nor systematically analysed by some trained observers sitting behind one-way-mirror . Thus subjectivity is bound to occur in selective reporting of observations retrospectively, however, despite these methodological limitations, the investigator as a trained group therapist, who has been successful in providing a forum for long term treatment of group therapy to a sizeable number of patients and whose treatment remained monitored by a Senior -Resident/Consultant Psychiatrist in the setting of a teaching-cum-research institution, has attempted to document this work dispassionately and objectively as far as possible. The present documentation by her may provide data on group therapy in Indian setup which may be used for any future well planned scientific study.

Rationale for selecting two major phases in therapy groups

Participation in psycnoanalytic group therapy seems to be possible when patients are given exposure to freely talk over an extended period. Patients' mental activity and their own capacity for psychological sophistication to express and reflect memories, inner feelings, thoughts, dreams etc. are important. This facet of mental activity in the group during patients interaction emerges with one another directed to watch the solution of problems for which individuals seek help. For an examination of the development of therapeutic process, wide range of varied theoretical perspectives have been evolved. Bach (1954) perceived the group moving from initial interpersonal testing phase to a relatively stable clinical work phase. He identified seven salient developmental stages (1) Initial situation testing (2) leader dependence (3) familial regressive (4) associative compeering (5) fantasy and play (6) in-group consciousness (7) the work-group The work - group is the term used by Bion (1952) who considered the primary-task of the therapy group to be the exploration of its own intra group tension which at times the group appeared to be pursuing in a rational and cognitive manner. But at times the group was also dominated by certain massive emotional states obstructing therapeutic process and resulting in behaviour incompatible with the primary task he had described them as (1) aggressiveness, hostility and fear (2) optimism and hopeful anticipation (3) helplessness or awe.

Martin and Hill (1957) have identified six phases. Geller (1962) four, while Coffey (1962) suggests no particular sequence. Whitaker and Lieberman (1969) have identified two such phases. A major task for therapists is to describe the fluid yet orderly manner in which the group process develops. For example, Bion (1961) described the group as continually shifting from operation on one 'basic assumption culture' to another. He has described basic assumptions as dependency,

pairing and fight. During the period in which one of them prevails, the others exist in latent state, e.g. if the dependency work- group culture predominates, the members act as if they are helpless and need support from someone out-side. In their efforts to establish such a culture, the patients may seek a certain relationship with the therapist or seek security by relying on their own history or procedures. Other theorist view basic assumption culture as solution arrived to a particular elements or resolution of issues in the group. Coffey (1962) described these issues as (1) the relation of the individual to the group (2) the problem of authority (coming to terms with the relationship with the therapist) (3) the problem of conflict (dealing with differences within the group (4) the problem of consensus or developing emotional support.

The present document seeks to summarize earlier theories in which the present investigator was trained and arrived at by applying and testing them in groups as well as made her possible to explain the clinical observations of therapy groups in terms viz. (1) to be regarded as initial phase of therapeutic process (2) developing towards to be called a 'mature phase'. Group therapy is not merely a collection of some patients sitting around with a therapist in a hospital or clinical setting. One should remember that patients at times experience profound fears of destroying or being destroyed, have overwhelming feelings of love and hate, intimacy and suspiciousness towards one another as well as towards the therapist. In the scheme of Bion's fight-flight culture, they are seeking a leader who can define an enemy. The ingredients that must exist in order for therapy to work in the scheme of client-centered group are : need for safety, psychological and emotional intimacy, mutual-trust, risk-taking, psychological openness, process of feed-back giving rise to creativity and imaginativeness - how to deal with problems of social environment with newer ways of adaptiveness

and coping. These result from social development in the group and transfer of learning out-side the group therapy (Rogers, 1970).

In this context it is pertinent to emphasize that in the present day psychoanalytic training a lot of emphasis is given to the knowledge and skills which are required in establishing first the working - alliance or as therapeutic - alliance, both in carrying out individual or group psychotherapy. The present investigator must have intuitively made use of them as well as introduced certain modifications or even innovations during her therapeutic interaction within the complexities and group dynamics of the Indian setting. However, always the clinical assumption is that a group exists, as distinct from an aggregate of individuals, as an essential part; regression in the group involves the loss of 'individual distinctiveness' (Freud 1921) and therefore obscures the fact that the aggregation is of individuals (who formed the group).

In an effort to understand the unique quality of a small group (both open and closed) and its state of group- work (including dealing wht impulses and fears which were inferred through patients' reactions to each other as well as to the therapist, in verbal and non-verbal term), two phases in the extended period of group therapy have been viewed to be of great importance viz. (1) In the initial phase, the manner in which each patient participated in, contributed to and reacted to the group setting with (leader) therapist. The first twelve to twenty sessions in the open group therapy (over the extended period) are being viewed as 'initial phase'. These sessions were not only informative but largely later binded the affectionate ties among members and identified the 'central person' around whom the group was forming. It was not necessary that this central person invariably remained the therapist; through the common feelings directed towards the central person the remaining members developed 'group emotional ties' with one

another.

In the initial phase, early drop out of members was frequent and followed by quick replacement by new members. Here the therapist's role became crucial in handling the affective characteristic and their reactions seen in the group in flux. In case the central person had decided prematurely to quit the therapy, it was bound to evoke the focal-conflict in the group and later sessions were towards resolving his/her loss. A similar situation occured when ever the therapist was required to discharge a member who had sufficiently improved to be discharged (This followed either having successfully attended the group therapy for a long period of two years or having had resolved problems for which had entered into treatment or changes brought into life situation or change seen in the psychopathology due to natural course of an illness etc..) Later in a mature phase, discharge; drop-out or replacement certainly had a different impact on therapy group. Although there was always a welcome and emotional support given to a new member, there also was a deep seated resentment over it at the same time once the initial phase was over. The question of 'proper timing' for entry of a new member in the open - group (which had already run sufficiently for extended period of time) depended upon therapist's successful operation of selecting the 'proper timing' and the ability of the group to continue working without break - down. This seemed to be inter-related with the composition of group, members' personality characteristics, leadership pattern of the therapist as well as the new member's ability to preserve his individuality while maintaining interpersonal interaction in the group process, despite group pressure and at times opposition against him by the group forces. At this stage with in groups the interpersonal tensions and conflicts get too much sharpened related to demographic issues or socio-cultural differences like age, sex, socio-economic status, state,

language* etc., which at times create a communication gap. Although the therapist invariably discusses these with group members and takes a joint decision before allowing any new member, or earlier drop-out reentery in the on-going group, the members are required to work - through their resentment over it or/and rivalry towards the therapist. The therapist also had to be more attentive to emotional reactions and to get actively involved in resolving them quickly. Several theorists have pointed both to the potent - effect of the therapy and the group's coping capacity. 'Coping' is a term applied to dealing with emotional issues in the group processes which have been also referred as 'group maintenance' or 'interpersonal homeostasis'.

It is widely recognised that in the initial phase, a group in therapy moves into a cohesive unit by cooperation and mutual support (probably due to increased altruism, universality of the problem and interpersonal learning taking place with mutual trust, self-disclosure, catharsis and gain of corrective emotional experience). After group has already worked-through the problems of intimacy and closeness, or in the later stages of the therapeutic process when ever a new member enters group regresses which gives rise to 'communicational restriction'. Although altruistic group members suppress expression of their hostility and resentment and extend gentle love and emotional support to the new member, unless resentment and deep seated emotions for disrupting the group cohesiveness are permitted to emerge and get fully worked through, it not only hampers the therapeutic process but also sharpens the group members' perception of individual differences among them.

However, in the course of long term treatment of patients of various dispositions and psychopathology, the

* Patients talked usually in Hindi or English but resorted to regional dilect in their mother tonguc under group tension.

therapist maintains that nothing remains totally constant and unalterable, the therapist's personal integrity, firmness, compassion and clinical understanding are required to come into play. A large number of patients in group psychotherapy can be benefitted provided the therapist is having no personal bias especially about whom she should treat or not to treat which springs from ones' own counter transference feelings. Rather self-awareness of counter- transference feelings and their frequent and continuing scrutiny can provide directions regarding how to address and resolve them promptly.

Countertransference feelings are resolved by professional attitudes. In the process of psychotherapy both pleasant and unpleasant affects require to be expressed and worked -through. In fact, by dealing with emotional tasks and conflicting feelings effectively the groups can move towards maturity. Both in the open group and closed group the sequence of events must undergo ups and down for therapeutic change to occur. By participating in the group situation, the patient may achieve some personality reorganization which allows him to function more adaptively. The therapist plays a crucial role in influencing therapeutic experience of each patient.

Countertransference feelings can also arise on money matters related to collection of fees which has been highlighted in the existing literature on the subject. Freud recommended that the psychoanalyst should charge fees even for sessions which the patient missed. These issues reflect the special emotional loading of money in the Western culture (especially U.S.A.), therapist's own financial needs and guilt feelings and attitude in collection of her fees. In the Government run hospitals medical treatment is provided without charging any fees and long term psychoanalytic psychotherapy is also possible (Dube, 1997). However, there is much more and sharper conflict about fees in the group than in the individual psychotherapy. A patient in the individual session can appre-

ciate the fact that the therapist derives her income from this source and therefore she is entitled to charge the fees from cancelled hour. But an absent group member is likely to reason that 'when other members of group are being treated paying the therapist why he should be charged for a missed session ? A therapist is likely to be far more embrassed by discussion on money matters in the group setting especially while handing the issue of an individual member's payment objection. In this book, the therapist's problem with fees have not been highlighted since open - group therapy was provided without charging any fees; in the closed - group only a nominal fees was collected at the registration counter it self by the receptionist before starting the group therapy.

When psychotherapy is provided free, a certain amount of mutual trust between the therapist and the patients is necessary. The public image of the Government run hospitals visited by a large number of patients is high in our socio-cultural setup. The misuse of the clinical services as well as disputes over doctor - patient relationship therefore are likely to be minimal. But among the difficult patients (especially Paranoid Schizophrenia and Psychopathic Personality) mis-trust and doubt requires to be resolved amicably by undertak-ing certain precautions during establishing therapeutic alliance.

Despite therapist's ability of establishing a proper therapeutic alliance, conflict is inevitable in the course of group's development. If conflict is denied, suppressed or eliminated by nipping in the bud (early therapeutic intervention), it will manifest itself in oblique, corrosive and even ugly ways. Rather an analytic therapist tries to harness conflict in the service of the group therapy because members in the group, in variety of ways, profit from conflict, provided its itensity does not exceed their tolerance (ego-strength) and therapy group has been based upon established norms. Tension has two important conceptual properties (Lewin, 1947) viz.

The first property is that state of tension ends to equalize itself with the amount of tension in the surrounding system (the group as a whole).

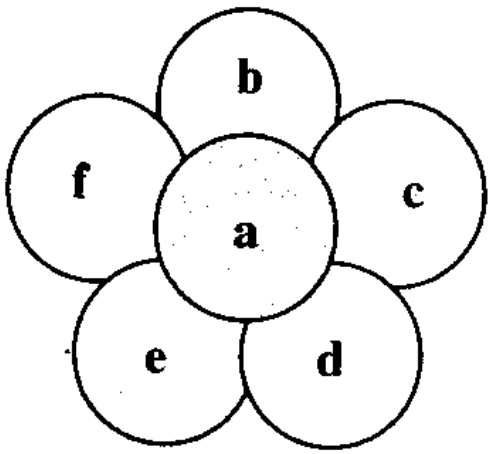

FIGURE 1 : Intrapsychic tension high in member a

As shown in Figure 1, if a patient is in a state of high tension and if other patients viz. b,c,d,e and f are in a state of low tension, then tension will tend to pass from a into b,c,d,e and f until there is an equality of tension throughout the whole system as shown in Figure 2.

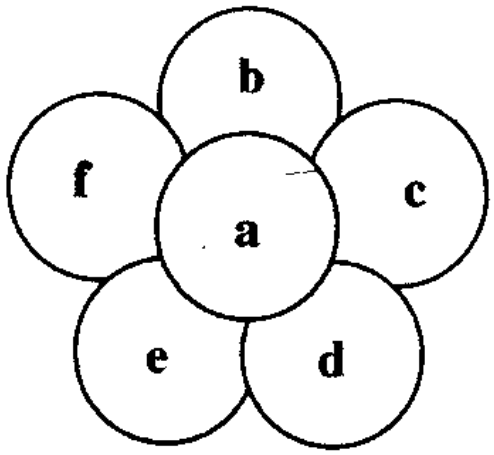

FIGURE 2 : Interapsychic tension high in all members

The psychological means by which tension becomes equalized is called process. In therapy process proceeds or gets blocked through patient's verbal or nonverbal reproduction

- thinking, remembering, feeling, perceiving, acting etc. In therapy tension always moves towards a condition of equilibrium. This conceptual property applies only to system as a whole and not necessarily to all the part system (See Figure 3).

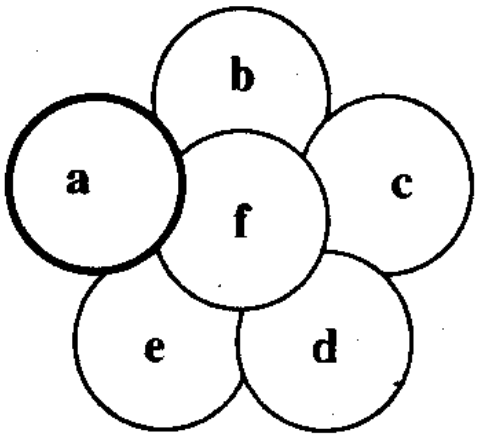

FIGURE 3 : Dark line & standing out member in the group process

A patient may actually become more and more tense during the time the whole system is returning to a balanced condition. For example a patient may be responding to others, not on the basis of reality, but on the basis of image of the other distorted by his own past relationships and current intepersonal needs and fears which is due to transference or "parataxic distortions". This member might be seing in other member/s aspects of significant individuals in their lives. If the distortions are negatively charged one and in the initial phase of therapy then mutual antagonisms may easily be intiated. This is called 'mirror reaction'. The form of "parataxic distortion is particularly common source of hostility in therapy group. Such individuals may have suppressed some traits or desires of which they are ashamed; when they encounter another person who embodies these very traits, they generally shun or experience instant dislike. This process may be closed to the subconscious, or to be recognized easily with the guidance of other members or may require several

months of therapeutic investigation. However, the development of group process tries to bring insight into this patient. For example, some members may undertake the task of enlightening him or/and pateint might realize and endure increasing tension anticipating that the end result will be a more perfect balance of his inner forces.

A patient who established an equilibrium on high tension level differs from other members in the group (See Figure 3) compared to those who have experienced low tension level. Such a patient will show a great deal of diffuse, restless, verbal and motor activity which would make him stand out in the group process. The other members in the group become more and more tense during this time till the whole system returns to balanced condition.

The second conceptual property of tension is that it exerts pressure upon the boundary of the system. If the boundary is particularly firm, the diffusion of tension from one system to adjacent system will be impeded, but if the boundary is weak the tension will flow from one system to another systems (See Figure 4). This interaction is called dynamic communication and is a variable condition in group therapy.

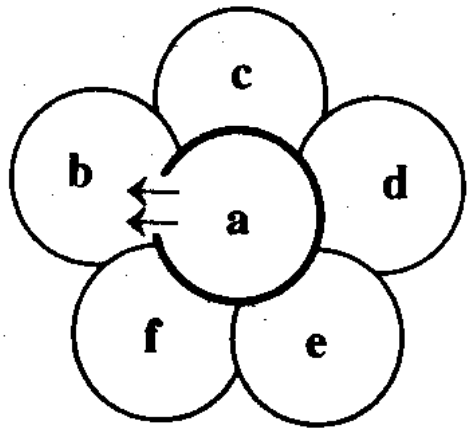

FIGURE 4 : Opening circle and arrows = a member opening and being interacted as "identified tensed member/patient" in the group process.

Dynamically speaking a boundary is a region of resistance or restraining force. The emergence of hostility towards the therapist is an inevitable occurence. A number of therapist have emphsized an early stage of ambivalence to the therapist coupled with a resistance of self-examination and self-disclosure in therapy groups.

External variables in the open group therapy

There are some unrealistic expectations about the doctor's role (to be performed by a doctor/therapist) which especially were seen among patients who lacked social support in our welfare state. Probably because medical treatment is usually provided free of cost in the government run-hospitals. These patients required several environmental- aids and assistance to be given e.g. free medicine, food, place of lodging and boarding besides the social support network of care- takers. Encouragement and hope in the type of treatment provided needs to be given to a psychiatric patient. At times, non-compliance in psychotherapy (of any form like individual or group, behaviour a psychoanalytic) was due to lack of proper social support system available to these patients in the analytic setting. Any chronic disease treatment requires a long term compliance by the patient and his care takers in the treatment. Therefore, the treating team members require to pay attention to environmental stresses and strain as well as to emotional factors posing non-compliance.

The analytical setting in which the present long-term group therapy was carried out had certain advantages and disadvantages. AIIMS being a teaching cum research centre, which has become famous as a premier medical centre in the country, its administrative procedure of registration and case filing, diagnostic screening at several levels till the final diagnosis and treatment gets prescribed by an expert doctor which comes through after a long wait in a crowded hospital

where insufficient facilities such as accommodation, privacy, and working hours (cut down due to holidays/staff strike etc.) do create rational and irrational emotional reactions in a an already emotionally upset psychiatric patient. Moreover, there is a stigma attached to psychiatric illness in our society. Even when the treatment is given in a general hospital setting, the fear of loosing dignity or adverse comments of people or relatives is very much there. Patients are quite fearful about risk of loosing their confidentiality even when assured that their case material will be used only for teaching-cum-research purposes. In this context one should not assume that the present investigator was unduly obliging, intrusive or domineering and left the patient in anxiety either to take the free treatment on terms and conditions laid down to them or leave it. Contrary to this, there was the feeling of joy seen among patients having finally come across someone who could understand their long term distress and possibility of availing the prescribed treatment.

In order to establish the therapeutic - alliance or contract in carrying out group therapy, the therapist first interviewed and discussed individually with the patient in privacy and then with accompanied family member before allowing them to come for their evaluation for group psychotherapy. For this the following procedure was maintained throughout the initial phase till the discharge from group therapy programme in order to control the environmental variables as well as non-compliance.

1. The patient's willingness and ability to continue psychotherapy for a long period (more than two years) or short term (3 to 6 months) without breaking two appointments consecutively.*

* The open group met every Monday from 5 to 6.30 P.M. and later was changed to 10.30 A.M. to 12.00 P.M. on every Wednesday except on gazatted holidays or summer vacations or strike period when hospital was closed down. An open session (without therapist) only once a month on the fourth Monday (later on Wednesday) of the month.

2. Re-entry into therapy was allowed depending upon the therapist's open hour for new cases. Never the size of the open group was less than six members or more than ten.

3. Psychotherapy referrals were made based upon psychodynamic considerations as well as the judgement of the clinicians regarding the choice rather than the patient's gender, socio - economic status, diagnostic category or the therapist's previous record of success with a particular diagnostic group.

4. Once the patient was referred for psychoanalytic therapy, psychiatric intervention was minimal. Yet, in case a patient needed adjunct drug therapy, he kept seeking the psychiatrist's help or in case of emergeney, the therapist herself sought consultation from the clinicians for psychiatric intervention.

5. Consent given for the collected material to be used for teaching-cum-research work.

The termination of group therapy of a patient was planned in consultation with a consultant psychiatrist (usually the one who had initially referred the case). It depended upon when the insight could bring about demonstrable changes in terms of modifying or preventing symptoms, infantile needs and defense operations, adaptive personality changes in those areas which earlier were emotionally distressing or changes in symptoms and behavioural patterns towords the family member/s but after treatment were felt to have been improved. Another index was that patient subjectively felt improved and could actualise his potential better - in terms of work, interpersonal relationships and zest for life.

Several patients required more than one session and some even individual psychotherapy to resolve their resistance to the group therapy treatment. The source of their resistance required to be understood and worked -through to a certain degree of smoothness in doctor-patient relationship to develop

before formulating the therapeutic alliance with them. The resistance is a defense reaction of inner forces, a psychiatric patient opposes the treatment of any kind, more in psychotherapy initially, although consciously he is eager to co-operate or willing to do anything the therapist asks him to do - as if he wants to get well at any cost. This clinical observation made by several psychoanalysts is of a great significance in understanding conscious and unconscious motivation, because the severity of the symptoms and the subjective distress with which a patient presents to us, are generally unreliable guides.

As a rule, when a patient is resisting one should call attention to it and prepare the patient to begin the exploration of the reason behind his inability to bring out any further information. This is carried out through verbal and non-verbal techniques. The author had observed that some patients came willingly for psychotherapy evaluation on the advice of their treating physician. They came inspite of being convinced that they were suffering from some organic disease, which had not been thoroughly investigated. To explore this kind of compliance, the therapist frankly asked the patient his opinion and preconceived notions regarding his symptoms, expectations from the prescribed treatment before establishing therapeutic - alliance with him. At times it required educating the patient about the etiology of functional diseases and the nature of the treatment of psychotherapy as well as his misconceptions about the prescribed treatment.

When a professionally competent psychotherapist decides to take on a patient for therapy, the procedure of psychotherapy (having undergone the initial resistance resolution), usually brings quick changes which can be observed by patients/relatives especially in the degree of the anxiety and somatic complaints. The following modifications of classical psychoanalysis technique were required to be made with

patients who looked psychologically - unsophisticated.

1. Passivity in therapeutic interaction to be replaced by activity in handling of issues of resistances and transference reactions.

2. Free-association to be abandoned as a 'fundamental rule'. Interviews to be either semi-structured and focused type to be conducted/ at the pace (speed) of the patient in a free floating style of focusing his attention.

3. The 'Couch-position' is not imperative. (it is not required in the group therapy but in the initial phase some patients do require relaxation to be given to them so a separate arrangement for relaxation exercise was provided) but supine position may be used only for relaxing and enabling the patient to relate, without feeling awkward, while talking of censored topics.

4. Positive elements of good doctor-patient relationship to be encouraged, like, rapport to be developed further into transference reactions.

5. Both conscious and unconscious material to be discussed in therapeutic sessions. The patient to report day-residual, psycho-social stresses as well as somatic complaints, sleep-pattern, dreams, fantasies etc. and make his own mental notes or keep a diary for bringing such material to the therapist.

6. Regarding frequency of appointment, length of interview, mode of cancellation and what procedure to be followed in case of interruption of treatment, visits in emergency and telephonic contact should be discussed in the initial stages and regarded as mutually agreed upon commitments, However, transgression from such rules should not be interpreted as emerging from unconscious source; usually classical psychodynamic interpretations are avoided but examples based upon common sense to provide insightful work in a corrective emotional atmosphere.

7. Any type of payment out of feeling of gratitude towards the therapist for providing free treatment to be de-emphasised Patients to be told that the therapist has been employed as a Government servant and it is the duty to provide the best medical services to all the patients. However, it is quite acceptable if a patient wishes to present a small gift to the therapist/treatment team/staff working for the welfare, out of gratitude.

8. Patients to be discouraged from bringing invitations for social get together in order to ensure full confidentiality.

Attention requires to be paid to transference reactions emerging from socioculture setting which are present and are beyond control of any therapist. In an analytic therapy, an indispensable principle utilized as a tool is to bring out recapitulation of the primary family experience back to therapeutic process. In psychoanalysis, transference-neurosis and its successful resolution is a must for therapeutic change to occur. However, now a days several therapists do not hold the same view point. Since patients depend on the therapist whom they view with unrealistic expectations of power, attitudes of love, hate, fear etc. while entering psychotherapy, they require to learn how to cope up with them or give up as Yalom writes (1970, page 12).

> The psychodynamically oriented group therapists view that : members grow up as it were in the group, and often with great difficulty, strike out into the world on their own. There is considerable emotional interplay between the therapy group and the primary family group experience. Experiences in the family will influence the patient's behaviour in the group and his attitude towards the leader (the patients) and other members (the siblings)"

In the therapeutic process one sees a considerable inter-member competition and sibling rivalry for gaining the favour

of the therapist. Therefore, working through of the transference - reactions and insight of the patients into the source of their distorted vision in the group process have led to discussion of transference phenomenon from several view points. However, it has been widely recognized that transference must have a different character from what it does in the two-person therapeutic situation. In individual psychotherapy the therapist is relatively a neutral figure, but in group therapy, there are more people present and they interact with each other in a spontaneous manner and provide verbal and non-verbal information to each other as 'real person'. Therefore in the therapy groups a multiple transference reactions' has been seen to-occur. Efforts to understand transference phenomenon in therapy groups have led to various definitions of transference like libidinal, sibling, and identification (Slavson) Some have even made this concept the corner stone of their theory (Ezriel, Wolf and Schwartz and others). A distinction is often made between `transference' and `mirror reactions', the latter term refers to experience in which the individual perceives some aspect of himself in another Group therapy presides a special means of self observation and objectification.

The research evidence dealing with patients' perception of curative factors in psychotherapy has indicated that transference issues are not of paramount importance to patients (see references Yalom 1970). Behaviour scientists hold that doctor-patient relationship appears to be complexly compounded by a number of cultural, social and personal factors. In order to study the doctor-patient relationship in the clinical setting of Government run general hospital, the present author had prepared a semi-structured questionnaire in vernacular language of Hindi (See Appendix I) which was distributed randomly to two hundred patients (a sizeable number of willing indoor patients) in February, 1973 at the AIIMS' general wards of Psychiatry, Medicine and Surgery. The three junior

residents who had been allotted beds for looking after these patients, personally distributed and collected the filled forms, assuring the patients that their information would be kept confidential and utilized only for research purpose. 70% of the patients had responded by filling out the questionnaire, the non-respondents were unwilling due to seriousness of illness or inability to read and write or could not understand 'what is being asked'.

The positive attributes given to a doctor were like 'Guru' (next to God), 'able to listen and understand pain', 'relaxing', as well as negative attributes viz greedy, selfish, unable to keep confidentiality etc. Both positive and negative were ticked were by majority of three diagnostic group of these patients (90%). The psychiatric patients ticked more often negative attributes to the doctor like 'frightening' or 'emotionally up-setting', 'sexually provocative', than non psychiatric patients. At the same time, a majority of the psychiatric patients viewed the doctor as 'an ideal mother' or 'ideal-life partner' where as none of the patients in other two groups of medicine and surgery made such attribution.

This exercise has shown that it is necessary to differentiate various aspects of transference as the term is being commonly defined. The term presupposes that the patient develops over time a transference relationship with the doctor/therapist or other patients in the group. That distortions of reality takes place in expectations and reactions centering around the transference object which are inappropriate (e.g. in the above study doctor being seen as ideal life partner or emotionally upsetting or sexually provocative). Simulation of personal history (psychiatric patients usually have emotionally upsetting life events both of past and present) occurs in which the current experience triggers (due to over sensitivity and heightened vulnerability) recapitulation of past relationships which are emotionally stressful or upsetting in

nature. The Indian socio-cultural expectation from a doctor is 'nurturant leader', 'selfless' and 'enlightened Guru', if such expectations are unfulfilled and create negative transference reactions easily, even though the doctor may be acting in a neutral, skillful, highly professional manner especially among psychiatric patients in government run hospitals; such transference issues bound to raise counter-transference reactions therefore the doctors require a proper understanding and handling of them.

Procedure of Analysis of empirically collected data

This book is based upon an indepth study of therapy groups. The findings are being analyzed and presented as a series of propositions derived from initial and mature phases of group therapy in the Indian setup in a holistic manner. This may be used to plan and undertake a systematic and enlarged study in future. It may also provide group therapists clinical insights to carry out treatment of group therapy in similar socio-cultural settings.

Chapter 3

Results

Initial Phase : Selection of Patients

The smooth functioning of long-run open therapy groups seems to depend largely on the proper selection and screening of their members. Unless careful criteria of selection and exclusion are used, it is likely that a majority of members assigned to a therapy group will either drop out or terminate their treatment prematurely without any benefit. There is considerable agreement among therapists that patients with brain damage (organic etiology), paranoia, hypochondria, addictions, alcoholism and certain personality disorders like psychopathic and narcissistic are unsuitable for long-term intensive group psychotherapy in the outpatient setting. It is also agreed that such patients, especially those with personality disorders, become active members initially and even try to play the role of co-therapist. Nevertheless, over time they are unable to relate with others due to their egocentricity and manipulative dramtic behaviour.

> Mr. M., who had a history of alcoholism among the males in his family, is being cited as an example. He was admitted to the ongoing therapy group along with a new female patient since drug psychiatric treatmet of both in the indoor ward was unable to help them. Their detailed case histories were presented in the weekly clinical teaching conference, where it was suggested that psychological methods of treatment be tried.

Mr. M. was 38 years old, formally not highly educated. He had married outside his community and lived with his wife, two schoolgoing children and elederly parents whom he had to support. He lived in a joint family set-up. He cultivated literary knowledge on his own, published poems and articles in magazines, and was an active participant in socio-political activities along with holding a job in the media. His wife, who earned more than he did, could never cope with his heavy drinking bouts, which were followed by family quarrels. On several occasions she had gone away to her parents' home along with their children, which made Mr. M. more insecure and resulted in heavy drinking. Mr. M. had been in individual psychotherapy with his treating psychiatrist, whom he viewed as his 'personal close friend'.

The therapist, before allowing Mr. M. into the group, had interviewed him twice along with his wife. His wife at that time had left him with his parents becaue soon after his discuarge form the psychiatric ward he had resumed heavy drinking. She was quite pessimistic about of his future recovery, but at the behest of the therapist returned home with their children to give her husband another trial. Their older child, a girl, was said to be quite attached to her grandparents and father. Her frequent separations from them had been followed by fits (hysterical). Both parents were quite concerned aboutthe health of their daughter, and therefore Mr. M. willingly came to the group therapy.

Mr. M. was added tot he ongoing group along with Miss B., who was 28 years old and lived alone in a smal single room on a roof (a barsati) in a commercial area and was searching for suitable employment. She

was a qualified architect and had recently become unemployed. Her mother and elder brother were staying with a distant relation's family far away, so they knew little about her recent problems at work and with her coleagues. Miss B. was also interviewed on several occasions individually as well as with her mother, soon after her discharge from indoor treatment following a suicidal attempt, before being taken into group therapy. The mother-daughter relationship was found to have been maladjusted for a long time and had taken on a delusionary proportion of mistrust. But during her recent illness mother visited the hestital, Miss B. had to seek the help of her mother. Her mother looked an emotionally unstable type, was found confused and pleaded often to be told how to take care of her highly educated intelligent daughter who 'liked living in a modern way'. Miss B. had been diagnosed as suffering from 'paranoid schizophrenia with the risk of sucidial attempt'.

Mr. M. opened up easily in the very first session, talked at length about his family tension and showed his determination to give up his drinking habit. He emphasised that in the past he had given up alcohol on his own. He said alcohol was not his problem and spoke of having lived with family tension and of struggling with povety due to the excessive drinking of his father. In childhood he hated alcohol and his father's habit of excessive drinking, but soon after his elder sister's marriage and his own he got into the habit himself. Whenever he got into tension at home or at his workplace, he resorted to heavy drinking.

In subsequent sessions Mr. M. showed a speedy recovery, not only in terms of alcohol abuse but also in improved interpersonal relationships with his wife

and children. He thanked the therapist and group members for bringing peace to his family life. His wife also came forward to report the rapid improvement seen in her husband.

On the other hand, Miss B. in the first session did not open up in the group except for talking of her urge to go up to the fifth floor of the hospital's private ward and jump (which she had tried, though timely intervention saved her, on several occasions during her stray in the indoor psychiatric ward). However, when she talked of her suicidal impulse, she smiled and giggled like a small girl. A female member of group took note of this and confronted her with the statement, 'You do not want to do what you are saying'. The therapist supported this and requested Miss B. to talk of the inner tension which made her want to run away from the hardships of life. But Miss B. insisted that the therapist should give her an individual session for opening up as she felt the group might not understand her 'mental anguish'.

In subsequent sessions Miss B. was found unable to relate with the female member who had made the remark, though she sat next to the therapist and listened with eyes wide open to what was being said in the group. She interacted non-verbally mostly, thoug she also talked in English with educated young male members who were concerned and enquired directly about her employment status or about the insecurity of living in a 'barsati' in the winter. By and large, she kept aloof and was found not perturbed much about her existential problems. She impressed the group members as a sensitive, intelligent and courageous woman though physically frail and quite undernourished. She looking young, like a teenager,

and wore her clothes untidily. She invariaby came late to the sessions, saying that she was looking out for an opening or had to meet someone in connection with work.

The rapid improvement of Mr. M. as well as his own interpersonal warmth and sensitivity towards group members made Mr. M. quite a social-emotional leader in the group. He was spontaneously drawn towards depressed patients and made them interactive by his humour and affectionate ways. This soon had him playing the role of a co-therapist.

One day Miss B. come late as usual and announced that she had come to say goodbye to members and especially to take the permission of the therapist to kill herself soon after leaving the meeting. She put this emotionally charged message without any indication of anxiety or sadness, which astounded the other members. Previous to her arrival the members in the session had been listening what Mr. M. was narrating in a boastful, joival manner about his childhood truancy in school and of spending time with his peer group in nearly cemetery so that they could collect some money and eatables without being found out by elders. He too had narrated all this without any associated feelings of shame or remorse. A male member who was quite hostile and envious towards Mr. M.'s increasing popularity in the group, suddenly lost his temper at Miss B.'s interruption. He shouted at Mr. M., 'You have not come here to talk baout yourself boastfully. We were quietly listeneing to you but we are not a cemetery for you to play in. Now Miss B. wants to end her life. What would you suggest to her?'. At this juncture the therapist intervened by saying that all had not listened to Mr.

M. or Miss B. as if they were playing peacefully in the cemetery. The message given by Miss B. was of the most concern, and after closing the group session all could stay on a little longer to listen her, or later the others might take her out for a cup of tea in order to pull her out of her despondency (which the therapist would not have allowed in the usual course of group therapy). But Miss B. would have to wait until the next session before deciding whether to commit suicide or talking in detail of her reasons for contemplating such drastic action.

In subsequent group meetings there were more affectionate exchanges and concern was shown, and Mr. M. openly addressed and envious male member, saying 'One should always get anger out rather than keep brooding over grievances'. However, sub-groups were being formed, one of males headed by Mr. M. and the other of female patients along with the angry male member. Miss B. was given time by th therapist for an invididual session and in this first time came to know of Miss B's failure in love.

Miss B. did not come for the next two groups' meetings, without giving any intimation. The group was already divided and discussed the 'violation of norms', not mentioning any one name in particular. One sub-group felt strongly that latecoming or frequent absences were distrubances to them. Amidst this; the therapist was informed by a male member of the other sub-group that Mr. M. was drinking again. When therapist asked the member how he knew, she learned that after the previous session Mr. M. had taken some male members for refreshments in the hospital canteen and that later one of them joined him in drinking in a dark corner of the hospital lawn.

After this exposure Mr M. vanished from group therapy but for a considerable time kept the therapist informed about his progress whenever he came across her in the hospital. His follow-up notes showed continuing alcohol abuse in periods of family tension, which led to divorce from his wife and separation from his children. He required indoor medical treatment for stomach ulcers and kept steadily declining in physical health.

This account is of an unfortunate outcome, but it demonstrates that the inclusion of an alcoholic with personality disorders in a heterogeneous out-patient group of psychiatric patients is to be avoided. However, one should note that in government-run hospitals, treatment is prescribed on the considerations of likelihood of success rather than on research criteria. The therapist's attitude and philosophy, acquired wih professional maturity, seems to play a significant role.

In the situation described (drinking in public places in India is prohibited, and if the two patients had been caught they would have been arrested), despite knowing of the possible consequences, the thrill of risk-taking and indulging in a prohibited activity was not ony due to the physiologieal carving of the alcoholic but due to his poor impulse-control, which we see in the sociopathic personality. The other male had simply followed, and his guilt feelings were mellowed as blame could be displaced on Mr. M. as the leader.

But the therapist must trust all group members to act as responsible adults and prevent damage to the reputation of group therapy in the hospital, which might have closed down group therapy running in the evening hours. In order to work with the varied personality characteristics and socio-economic backgrounds of patients, the therapist must trust the group to develop its own adulthood potentials and test them. The role

of the therapist, as it is in individual psychotherapy, is one of facilitating the therapeutic proess like a good catalyst. She should be prepared to handle matters firmly but with human sensitivity whenever norms are violated so as to prevent such lapses in future rather than being authoritative and punitive. The psychotherapeutic process is always geared to learn how to handle unconcscious prohibited impulses with adaptive defence mechanisms.

Acceptance of the group

The acceptance of the group is communicated to its members by the way the therapist trusts them to come up with their own direction. This can take into consideration whether or not the group members are at a point in their own personality development that renders tham able to deal with emotional issues. The general rule of thumb in group therapy is that by not imposing guidelines on what to talk about or not talk about, the therapist also enables the patients to experience freedom to be creative and expressive. However, if this is followed too rigidly, especially in a closed group of young adults or adolescents, it may even provoke termination of treatment, espeically when patients are disappointed in their expectation of external support. The following is an example.

> A closed group was started at the request of some volunteer Fifth Semester undergraduate medical students who were at the Department of Psychiatry during their clinical posting. It was organised as a counselling group to help students to adjust more effectively to their posting to the psychiatric ward as well as to their own problems as young adults in a physically and emotionally tiring medical training.
>
> The group consisted of eight members, who were not screened by the therapist although she had some familiarity with them as a teacher. Along with her the

Professor and Head of the Psychiatry Department acted as co-therapist. but he sat silently all through the sessions like a passive observer. He was not ony their seniormost teacher but also an administrative head. Students looked at him with respect and felt obliged to maintain a distance from authority that is found in the Indian hierarchical set-up, even before he had directly interacted with them or in any way acted to establish his position in the traditional style.

At the first meeting. all the members introduced themselves and then looked at the therapist and the co-therapist expectantly. Their prolonged silence in the initial period itself turned into resistance. After a long period of silence (a non-verbal cue given as if the therapist was waiting for someone to talk), the therapist expressed her uneasiness by making the remark, 'This silence is not tolerable, at least to me'. All the members burst into laughter (but not the co-therapist), indicating that no one was willing to accept that the therapist could not toelrate the prolonged silence (in a medical setting people learn to carry out their jobs tight-lipped).

Meanwhile the co-therapist had lit his pipe and sat comfortably with his chair titled back as though he was aloof from the surroundings. Each one was looking overly careful and viewed the situation with uneasy suspicion. Probaby among the members (students) there was some fear of how their self-disclosure would be evaluated by their teacher. AIIMS is a residential university and by the fifth semester students adapt to the functioning system with its rules and customs.

Ir. therapy groups as well as outside there seemed a

silent agreement among them to keep quiet and not to appear to stand out in any way. The subsequent six sessions of this closed group were spent on such issues as who cam in late, who dropped out, where the next clinical posting was going to be and the quality of hostel food. The themes brought up indicated that these students required environmental support from their authority, which was not coming forth. They did not raise issues which related in any way to interpersonal or intrapsychic problems. When they saw both therapists not intervening, they felt dissatisfied but viewed this as if it was what they had expected from authority. They did not express their resentment but rather showed it by maintaining long silences which were indeed tiring. A few members approached the female theapist to express their dissatisfaction over the members' behaviour in the group and requested her to give them individual sessions in order that they could talk about their personal problems. Since the therapist had started this closed group without screening the members properly, she felt that she had no control over peer pressure taking over in the group. It was decided to close the therapy group and provide the two remaining members (others had dropped out making lame excuses) individual therapy.

In the individual therapy the two members co-operated very well and completed successfully nearly two years of psychotherapy. One member had opted for the medical profession due to family pressure and wanted to leave it. He could not do so as he was very afraid of the disapproval of his father. Moreover, getting a seat at the AIIMS itself had given him a special status. However, in therapy he could work through his oedipal

problems with his dominating father. The other student in individual psychotherapy worked on his cultivated interest in Indian philosophy and yoga and later came to join the subject of psychiatry for his postgraduate degree. In individual psychotherapy he could work through his dependency problems as well as his need to seek approval and external support. After finishing the M.D. in Psychiatry this student got married and left along with his young wife for higher studies, leaving behind the joint family business to which his parents were keen to keep him tied down.

Group attack on the therapist :

The following incident describes a situation that most group therapists are likely to face. It happened with the present investigator in the third session of her ongoing group therapy of an out-patients' open group. The group had started with eight members (five male and three famale), properly screened wih therapeutic alliance well established before allowing them entry into group therapy.

One male member who had quite actively participated in the first session and talked openly of his interpersonal problems within the joint family set-up was absent from the next wo sessions, without any prior intimation being given even to the therapist. In the third session he came in before the therapist entered the room. As the patients had gathered already, they were all interacting and talking. The therapist came to know later that the absentee had been asked why he had not been coming and had been told that as he had broken the therapy rule (consecutively breaking two appointments) his therapy would be discontinued. When the therapist entered the room, several conversations were going on as if it was a lively social

get-together, but soon after her arrival there was a prolonged silence. Each member looked expectantly towards the therapist and the absentee, who was restlessly sitting o the edge of his chair. The therapist, noticing this, asked casually, 'What is the matter with you? Are you in a hurry to leave?' Instead of replying he expressed his resentment over the rule of discontinuing treatment after two consecutive broken appointments. The other members could not support him in his viewpoint. He refused to give the reason for his not having come twice. Suddenly he burst out angrily and asked why the therapist had not directly asked him to discontinue the treatment and why one has to telephone or write to the therapist when requiring the cancellation of an appointmet. He openly questioned not only the procedure but emphasised his stand that he knew better what to do and what not to do. Then he abruptly left the room.

The group was then in the initial phase of establishing interpersonal ties, so no one got up to bring him back. The therapsit also was not sure at this state whether she should establish the procedural norms or bring back the falling out member into the group process and enable him to work through his joint family dynamics, which seemed triggered into the therapy group (apparently a multiple transference phenomenon leading the patient to acting-in). However, this member's angry outburst and departure had upset all the members and made them insecure and freightened. They felt oversensitively individually within themselves but could not react in anger collectively. But they displaced on the therapist, for several sessions, a transference reaction towards an omnipotent authority who was perceived as totally insensitive and callous on the departure of a family member.

The therapist realised the impact of the incident on the patients and their dee-seated resentment over it by some manifest behaviour as well as non-verbal cues. Subsequent sessions saw prolonged silences, patients talking mostly of somatic complaints of heightened anxiety, sleeplessness etc. They restlessly walked out of the therapy room on some pretext like feeling thirsty or going to the toilet. Some who were receiving individual therapy with the therapist confronted her with being too strict in maintaining procedural norms. They requested her to have consideration for their convenience and problems. They agreed with other members that the therapist, being well placed, could not appreciate the common man's difficulties. They projected resentment in terms of socio-economic differences as well as by saying that the therapist, being non-medical, could not treat their somatic problems.

This incident made the therapist resolve that procedural issues would best be handled by the group discussion method in future. Any matter related to a group member's violation of norms need not be decided unilaterally by the therapist; rather, the therapist should point to the members and ask for a joint decision on such lapses. However, the erring member should frankly disclose the reason for the lapse either privately to the therapist or by talking about it in the group. If a member wished to leave the treatment on personal grounds or any other consideration, he or she would be expected to state this and the group would then arrive at a common decision in consultation with the treatment team.

A disclosure near the end of the session :

It was his seventh session in which Mr. A. was seen sitting silently throughout when the group was engaged in

discussing a news item of great concern at the time. He had been fidgeting and extremely restless, ready to leave the room, but nobody took notice of this. The therapist knew that Mr. A. was quite distant from what was happening in the group but thought it was a matter of time before he would choose the appropriate moment to participate. This patient had maintained that his chief complaint was 'insomnia' and had impressed fellow members that otherwise he was a well-adjusted student. The group in the session was moving towards better cohesiveness and was on the verge of ending the session. Suddenly Mr. A. was seen crying. On the surface it appeared that he was giving vent to his feeling of anger for being neglected and unnoticed. But seeing him crying, other members were shocked and became immobilised. They looked at the therapist or at Mr. A. but were at a loss to say anything. The therapist's own spontaneous judgement was that this member was falling apart and needed extra time to console. However, some members had left and some were in a hurry to leave. The therapist along with the remaining members sat with Mr. A. to find out the reason behind his sudden ouburst of emotion.

> It came out that the previous evening Mr. A. had taken brown sugar after abstaining for a month or so. He felt guilty for his sudden fall as he had given up the addicition on his own without seeking any external help. Therefore he was unable to forgive himself. The sub-group which that day formed around Mr. A. was later quite helpful to him in the group therapy. One member openly appreciated his will power and said that after a few relapses he would be free of the addiction. The therapist too praised him for expressing his depression and for his ability to cry out for sharing his guilt feelings. If he had kept his guilt to himself and brooded over it, for the whole week he was likely

to have succumbed to his addiction and become more confused.

In later sessions it was evident that if feelings are openly expressed and timely catharsis takes place in the corrective emotional atmosphere of the psychotherapeutic process, then group therapy moves effectively.

After this incident supportive sub-groups started emerging among male members. The female members, though, from the beginning mixed more among themselves, sat and left together. Among the males they interacted only with an elderly man who was relatiyely depressed but well functioning. He was a senior engineer living with his wife and three college-going children and was never seen interacting with other male members after group meetings. The therapist came to know later that after the group sessions the patients went to the hospital canteen and there was intermingling between them as if the group process did not stop at the moment the group session had ended. The problems of their intimacy, rivalry and first-time openness to private life were brought to the group sessions much later. This was at times beneficial and sometimes harmful. In the later sessions the therapist started noticing that sub-group problems were affecting the therapeutic process, though there were spontaneously established human bonds of trust-mistrust, interpesonal tension due to split-transference reactions creating emotional dramas to be settled in therapy.

Male and female members maintain distance :

The female members of the group, from the start of group therapy, maintained a sort of a boundary between them and the male members. They had little difficulty in the

interpersonal testing and were seen socially interacting with one another smoothly, but this was confined strictly within the group session. When they had developed enough trust in an elderly male member they allowed him to enter their sub-group.

Mrs. P., who was quite amicable and liked by all the members, was mostly escorted by her husband, who came to take her back while returning from his office. She was a well educated housewife of 35 yrs., the mother of two schoolgoing children, and her husband worked in a government office. Mrs. P. had entered treatment for chronic depression and had received anti-depressants for long without much improvement.

The therapist had interviewed Mrs. P. several times, as well as her husband, before taking her into group therapy. She impressed the therapist as a sensitive person of literary interests, a middle-class woman who had not been given the opportuity to mingle with the opposite sex. She denied having any martial problems but talked frankly of her minor adjustments due to her oversensitive nature while living with her in-laws, especially the mater of not bringing dowry. She felt that her husband was the loving and caring type, and the husband also did not give any impression to the therapist of having ay marital problems except his concern over her health. He reported that at some point doctors had diagnosed that she had a congenital heart problem. There was a history of chronic heart problem on the patient's maternal side, which made her leave her studies and get married at an early age. Even after marriage and having her own children Mrs. P. was found constantly worried about her mother's anticipatory death anxiety.

In group therapy Mrs. P. used to talk mostly about her

mother's health and how as a young girl she was kept busy in domestic work and looking after seven younger siblings. She had cultivated the habit of reading before going to bed. She kept on doing this even after marriage, which made her husband at times impatient as he was tired and wanted the lights off so he could go to sleep. The elderly depressed male member with whom all other female membes were friendly was seen taking an active interest in Mrs. P.'s talk of childhood miseries as well as her interaction at night with her husband. He never asked her any direct question but enabled Mrs P. to talk in the group about her hobbies and intersts, what as a woman she liked to do, and what she expected her husband to do before going to bed. Male and female sexual needs and expectations were communicated in the group with utmost frankness which was through non-verbal cues of gestures and then by actual talk on sexual matters.

It became evident that Mrs. P. had for a long time felt sexual dissatisfaction, which she handled with humour and the denial of her personal need of foreplay. The other members listened to this conversation with rapt attention. Probably this was a theme of common interest to them, which seldom gets talked about and verified in the Indian setting with both males and females in a peer group. The therapeutic process turned into open disclosure and enabled Mrs. P. to say what she wanted the most in her marriage. She described her husband as having no knowledge of previous expereince of any loving relationship as he had a step-mother. he lacked romanticism which a woman wants most, though she felt that he was very dutiful, loyal and loving to her as well as to their children. She desribed her bedroom vividly. She felt

that on her wedding night it lacked a proper atmosphere as there was no blue light or a candle even lit by her husband. She laughted over the Hindi movie scenes and evaded talk on the topic, saying that men had no other interest and they required to learn the art of love-making from a beloved. In order to confirm her point of view she quoted a Hindi writer whose articles in a popular magazine discussed whether a wife can be a beloved or whether one needs to search for one outside marriage.

Mrs. P. was told affectionately by the elderly male member that she should not generalise about all men based on what she had experienced. He said that men also liked to be romantic and disclosed that at times he felt that his wife evaded him by finishing the household work and coming late to the bedroom, often after he had fallen asleep. His work schedule in the daytime was tiring, and as soon as he felt relaxed in bed he had no energy even to talk. He openly expressed his resentment that at times his wife was quite repulsive to him due to her manners and her nagging about their children's careers and marriage settlement plans, which seemed suitable topics to her to talk about in the bedroom. She spoke in a harsh loud voice which annoyed him and made him afraid that his grown-up children in the next room might overhear their quarrels.

He reported his inability to sleep without having his wife next to him. He felt drowsy but was not able to sleep, as if awaiting for her the whole night. His wife knew his weakness and made fun of him. That was the reason why he had never allowed his wife to visit her parents alone. Thus the theme of sexuality in long married life was dealt with in this heterogeneous

group due to the long-standing marital dissatisfaction among these two groups members, but it turned out to be of interest to all other members present.

Those days in the open group there was no single young female, all females being either married or separated or widwoed. One of these, Mrs S., who was recently married but separated, was staying in an outhouse (a servent's quarter attached to government accommodation) as her step-mother would not allow her to come back after her separation. Mrs. S. reported that her step-mother had ill-treated her and had her married against her father's opposition to a distant place in order to get rid of her. Mrs. S. had her first mental breakdown (diagnosed as catatonic schizophernia)), which made her husband send her back to her father all alone from the South India to Delhi. She had recently undergone hospitalised treatment and had resumed her previous job as a steneographer in a private firm. At this stage she was unable to support herself, living all alone in a outhouse of her father, who was economically well off, and otherwise quite forward in his views (being a journalist).

From the beginning Mrs. S. was quite talkative in the group, socially mixing with all male and female members, and was the first woman reported to have gone with male members to the hospital canteen as she used to come straight from her work.

Her unihibited social behaviour made the eldest male member of the group a little over-protective towards Mrs S. He started accompanying her after the gorup meeting to the hospital canteen and later to the bus stop. Mrs. S. might have accepted this arrangement to begin with but later became quite irritated and asked

him to stop it. Her uninhibited remarks in anger made the other male members more careful, and they later reported to the therapist that something was wrong with Mrs. S. This led to a confrontation between Mrs. S. and the elderly male member, and her talk was highly suspicious and humiliating as if the man was her own father. This transference phenomenon, to the therapist, suggested that Mrs. S. was going towards a second attack of mental illness, and group members felt that she was displacing her anger towards her father figure in a highly disgraceful manner. The deep-seated hurt of Mrs. S. (being abandoned by her father, who never gave her protection during childhood from the ill-treatment of her step-mother, nor to her elder brother, who left the family during his adolescence) came back to her memory, precipitated by the recent marriage mishap in which her husband had abandoned her in a mentally disturbed condition. However, this certainly had reached delusionary proportions in reacting towards the elderly male member in the group. In subsequent sessions, Mrs. S. was seen to rapidly regressed. She referred in a highly incoherent manner to being sexually abused before her marriage by someone in her office whom she had trusted and respected liker her father. When she reported the resulting pregnancy to the family, her step-mother made her go for an induced abortion and soon got her married to a distant place without providing adequate dowry.

Mrs. S. felt that it would be an honest act to reveal this private tragedy to her husband on the wedding night itself. Instead of being understood, she was abandoned and made to leave her husband's family immediately, in a highly emotionally perturbed

condition. Reporting this incident, Mrs. S. started weeping bitterly. Nobody in the group could,console her or stop her crying as she was in a psychotic breakdown. She at times spat on the floor and murmured, 'If I had my own child I would have lived alone all my life happily. I will never trust any man in my life'. Since Mrs. S: was found to be highly disorganised and the group members were keeping a distance from her, especially while leaving the therapist's room, the therapist had her admitted in the hospital for proper emergency treatment. She required this extra care at this phase but did not have the proper social support of her family. Soon after the acute phase was properly managed, Mrs. S. was allowed to come back to group therapy from the psychiatry ward itself. She was regular in her attendance and found to be quite dependent and trusting towards the therapist. She talked coherently about her private tragedy in individual sessions but never referred to it in group therapy.

Mrs. S. was kept on drug treatment and followed up regularly for five years. Even after discharge from the hospital, she kept up affectionate ties and impressed the treatmet team as an independent outspoken bold woman who kept herself aloof yet got on well with males. She lived with dignity on her own small earnings. Several doctors had attended to the treatment of Mrs S. but Dr. V., a young Resident doing M.D. in Psychiatry, who knew the mother tongue of Mrs. S., could establish a better doctor-patient relationship during her indoor treatment in the psychiatry ward. He had elicited a detailed history of this case by interviewing the parents. The reliable objective history taken by him showed that whatever Mrs S. had told us during her psychotic breakdown was also based on previous stresses of life events.

Entry of a co-therapist in the initial phase :

Dr. V. expressed interest in following up this patient in group therapy by attending the group meetings with a desire to learn group therapy. He was allowed to do so, but only after ascertaining his keen intention as well as after-evaluating his psychosocial maturity. Aso, it required to be discussed in the group whether they would permit Dr V. to sit as an observer. The members of the group were quite willing that he should be taken in as they felt that he was capable of providing them with good care which they experienced during their psychiatric treatment and/or undertaking of a detailed case work. His participation in the group as a trainee and co-therapist for next six months (until he passed the M.D. examination) was quite helpful. He enabled male patients to open up their concerns about male sexuality. Dr. V. was carrying out a research project on 'penile-erection', therefore, could willingly advised them on subjects like masturbation, premature ejaculation and homosexuality. At times some members sought direct advice and education on these psychosexual problems.

> It was after Dr. V. had sat in on a few sessions that the elderly depressed male disclosed on is own a deep-seated guilt for having had sex with his unmarried sister-in-law, who had come to stay during the first pregnancy of his wife. One night he was unable to sleep without having his wife beside him. In restlessness he had gone to sleep in the bed of his sister-in-law and felt being drawn passively into the sexual act. They had sex on a number of occasions until the sister-in-law got married. Nobody knew about this relationship, but before her marriage the siter-in-law told all of this to wife. Ever since, his wife had stopped trusting him and often made scornful fun of him.

After this disclosure this patient was seen keeping quite aloof and becoming very passive while interacting with other members in the group, though he listened attentively to what others were saying. At times he ws also noticed staring at the therapist with a vacant look. When the therapist brought this to his notice, he could not tell the reason behind it. He started sitting next to the therapist in order to avoid his habit. He had also started complaining of more somatic problems as if his depression had become more severe. In a subsequent session the therapist noticed his eyes were watering, but he denied feeling sad or being on the verge of tears. Rather, he shyly accepted the therapist's observation and politely remarked, 'Since childhood my face has been like this. People say I have a crying face'. Any direct interaction with the therapist was now followed in this patient by a somatic complaint, that he had started having severe headaches. But he refused to tell what had suddenly made him so anxious. The therapist was concerned about regression in his progress, especially for his depression which had not lifted despite appropriate drugs and psychotherapy. In the group he was perceived with respect, probably due to his age and gentle manner of interacting with others.

In order to prepare him for termination, one day the therapist asked him, 'How would you feel if you stopped coming to group therapy?' He stared at the therapist and could not reply. Later in the session he brought out his childhood memory. he used to regularly attend morning kirtan in a temple and later had played 'Tabla' with the musicians till he got a job and moved out of his home town. The therapist made a casual remark that he seemed to be coming to the

group therapy as in earlier days he went to the kirtan. For the first time (after a long time in the group) the patient smiled but made no comment. It was quite evident that the passivity and dependency of this patient were based upon his obsessive personality rather than on the psychopathology of endogenous depression.

The impact of the therapeutic - alliance :

The way a group therapist proceeds to establish the corrective emotional experience in the group (either by carrying out individual therapy combined with group therapy or by first establishing a good doctor-patient relationship) seems to enable the members of the group to express, on their own, feelings and thoughts to be shared with the group. The therapist's hope to convey to members that it is safe to be rlaxed and to speak of private matters in the anlytical setting, however, depends upon the therapeutic process which gradually develops into its mature phase. But providing an analytical setting alone is not enought for the group therapeutic process to emerge. This will become explicit from the following discussion.

A study was conducted on obesity patients attending the AIIMS Medical O.P.D. by the experts' team of the Nutrition Unit (Gupta et al. 1983). The patients who had excessive body weight of 115 per cent or more of the ideal weight (114 males and 21 females) were subjected to assessment of socio-economic status (Kuppuswamy scale), clinical history and examination, anthropometric measurements, dietary intake, self-rating of dpressive symptoms (Zung's Depression Scale) and Neuroticism (Eysenck's Personality Inventory). Results showed that a good doctor-patient relationship was essential to ensuring compliance with the instructions given for increasing daily physical

activity and descreasing dietary intake by observing fasts. Those patients who had scored high on Zung's Depression Scale and Neuroticism on EPI were provided, in a small group of 8 to 12, closed group psychotherapy treatment with adjunct anti-depressant drugs. The treating physician along with the therapist sat in the group sessions to see the effectiveness of group therapy.

The obese pateints' group therapy could not run smoothly as a majority felt that their problems were of body weight, and those members who opened up where found indulging in catharsis of their deep-seated neurotic problems of childhood or current stressful life events or environmental situations. The female members who opened up were fatalistic in their outlook and were hopeless and helplsess towards their own ability to change. The male members listeneing to their complaints were seen either becoming distant or laughting at them, and never frankly admitted that they were also concerned about their body weight. The primitive defence mechanisms of denial, somatisation of anxiety and depression were commonly observed among male members as if they were least bothered about having ugly bodies. The difference in perception of the body image in comparison with that of the females, who were found over-concerned and highly sensitive, created a sort of impasse in the group. As such, the males, who proportionately had greater overweight problems, dropped out quickly. This turned the group into females, taking over the group process. Their talk was mostly of interpersonal difficulties and family tensions, seldom about intrapsychic problems related to body image. The physician felt that the females had neurotic problems and should therefore

be treated either in individual therapy at the Psychiatry Department; or they could be followed up better by him while giving them drug treatment along with the therapist sitting beside him to provide support.

This experience of group therapy with obesity patients seems to indicate that the ineffective therapeutic process seems to be due to incongruence and lack of cohesiveness among group members, apart from issues of counter-transference in the therapist as well as in the co-therapist (physician). The way the individual perceived his or her body-image and the way it was experienced in the interpersonal relationships of the group, if it had become congruent (by resistance-analysis) then only member would have felt confident to share with others. If one is able to accept oneself one is able to accept others as worthwhile human beings without reservation or hesitation. This sort of positive regard given to one another permits smooth interactions to take place in group therapy and a mature phase to emerge quickly. This was probably the reason why a short-term group therapy (only of three sessions' duration) in a closed group of professionals turned out to be a success. This, however, will be discussed a little later. The view that group therapy situation develops and the manner in which it develops may be summarised as follow.

Propositions : the initial phase

1. The work of the group therapist begins long before the first group meeting. The success of the therapeutic process depends upon the therapist's performing the pre-therapy tasks of proper selection of patients, group composition and size, laying down the analystic setting's norms for time, place, fees, procedure for cancellation of appointments or for making extra appointments, telephonic consultation in crisis situations or to combat any such clinical emergency. The therapist and group members are required to establish a proper rapport, a

therapeutic alliance and a code of ethics to abide by.

2. The subsequent sequence of the group therapeutic process is to be conceptualised as emerging out of some common concern of memebrs, or their interpersonal conflicts or their wishes or impulses which the therapist clinicaly picks up from verbal and non-verbale cues, as well as affective climate prevailing in the group. The therapist addresses members by drawing their attention to associates various themes emerging in previous sessions in a sequential order and views them as a 'focal conflict' or resistance if the memebrs donot incorporate these suggestions.

3. When confronted with the conscious or unconscious emerging 'focal conflict', the members in the group attempt to resolve their tensions or anxieties while resorting first to 'resistance'. The resolution of transference reactions may be necessary, but it is feasible only when the therapist attempts to analyse the resistance in a common-sense and 'here-and-now' manner and avoids interpretations in terms of intrapsychic or psychodynamic formulations based upon her knowledge of psychoanalytic theory. To operate successfully the therapist evaluates the proper timing, speed of the patient for change (in terms of ego-strength and present state psychopathology), the emotional climate of the group, its composition, size and the phase of the therapeutic process in the group.

4. In the initial phase, the issues of orientation, interpersonal testing, hesitant participation, search for meaning in moving towards or away from self-disclosure in order to gain from the corrective emotional expeirence, this all will come smoothly through provided the group members aim to achieve to their level of expectation the goals for which they joined the group. Secondly, it is also important that the patients be able to resolve satisfactorily their need of social relationship among themselves while establishing affectionate

bonds by trust-mistrust, dependency-independence and love-hate. The self-corrections come gradually to the members through their experiences within the group and outside in their social relationships. The individuals differentiate themselves from others in their social relationships both within and outside therapy in their life. The bilateral interpersonal relationships based on liking, love, acceptance, and respect largely determine the extent of the individuals' growth.

5. In the initial phase, the group therapist tries to become a model to the members by providing the analytic setting for social relearning. The anlaytic setting of privacy, confidentiality, empathy and affective climate in the group makes for self-disclosure and enables members to resolve interpersonal and intrapsychic issues.

6. Members' successful solutions, taken collectively or in sub-groups, constitute the culture of group therapy. The elements of the group's culture define the character of the therapeutic process emerging from the initial phase into the mature phase in which relationships among patients and between patients and therapists set boundaries for their expressions of affect, acceptable content and accptable modes of social interaction.

Mature phase - a member mair tains distance

The realities of group culture and the patients' expectations are likely to generate conflict and uneasiness within each patient. In order to carry out on his own the therapeutic alliance, the patient feels he must reveal personal material not only to the therapist but also to the group members with whom he has interacted sufficieitnly and formed affective bonds. However, the patient is not sure about the group's ability to maintain the non-judgemental attitude which he will have seen already in the therapist. He maintains a distance, as if with a cosntnat debate going on in his mind about whether

he will be criticised or rejected or laughed at by the group. How can he reveal his angry resentment at this mature adult stage if it might destroy the reputations of his loved ones? Probably these issues are related to the early personality development and object-relationship of the patient, to be worked through in therapy, but they do create insurmountable problems.

The elderly depressed male patient discussed earlier was seen caught in this conflict. This patient had discovered that the therapist had some idea about his psychodynamics but that she was not addressing his problems in the group. He was angry that the analysis which he was expecting was not forthcoming in the group setting, and whenever the therapist tried to address this patient he expressed his resentment by forming somatic symptoms of 'tension headache'. The passive-aggressive sticky resistance of this patient could not be resolved, so he was provided a few individual sessions of psychotherapy. His problems of maternal deprivation in early childhood (his mother had died when he was six months old and he was brought up by an old grandmother and a step-mother), heavy family responsibility on his father, who did not earn much yet had to raise a large family, and resentment over it were discussed. This patient had a deep-seated anger towards his father but this was never discussed in the earlier individual or group sessions. He emphasised that he was good at studies yet had to pass a diploma course in engineering in order to quickly secure a paid job and help his father with family responsibilities.

This patient became more open in group therapy after receiving a few individual sessions, and on his own discussed his current domestic worries. His daughter

was married in haste to a NRI who was living in Canada. His daughter had to return to India as she found that the man was already marreid and had two children by his foreign wife. This cheating hurt the patient deeply but he could not express his resentment since he was the one who had arranged the marriage as he was not in a position to give a large dowry. His wife and elder son openly criticised him and never forgave him for the disaster. The patient was reconciled that his daughter came back safely and on his persuation got back to her higher studies and completed a professional course successfully. Later she got married without any dowry. - Though this patient had been coming to the group therapy all along with these family tensions, which had in fact brought down his work efficiency and were a cause of his existential depression, he had not opened up about them. He viewed his 'luck' as being responsible for his miseries and beleived that he might have sinned in his previous life.

However, during treatment itself, he got an overdue promotion which gave him a sort of moral boost. His son had also started earning and therefore the therapist felt that this patient was now ready to move out of group therapy. He was advised to come for a follow-up after three months. His follow-up also showed a steady work record, somatic complaints of depressive psychopathology mostly improved, and no more than an occasional tension headache. He too reported subjective feelings of well-being which he had not experienced since his childhood. His wife also reported that her husband had improved and that he had a new zeal for life. And she was particulary happy that her husband had stopped regularly attending the hospital.

The group members' reaction to the departure of this patient seems to have involved mixed feelings. He had earned some status among the members due to his mild temperament and mature outlook to life. Yet they felt jealous that he was given more individual sessions of psychotherapy and attention in the group by the therapist than they were able to get. There was in subsequent sessions a struggle among a few male members for gaining leadership status, and some females mourned the departure of a mature person from their midst.

At this stage in therapy each member had engaged more deeply in the group and revealed to others and to himself his problems of living. The richness and complexity of these will be made explicit by setting out the members' identification data, purpose of joining the group and continuing in it or leaving it.

1. Mrs. P., a middle-aged, educated housewife, mother of two schoolgoing children. Her husband worked in a government office. This case earlier discussed regarding her marital problems and history of chronic depression.

2. Mrs. S., a young female separated recently, living alone in the outhouse of her father, working as a stenographer in a private firm. Her recent attack of catatonic schizophrenia was precipitated by a traumatic life event. This case also discussed earlier in connection with second attack of mental illness during therapy.

3. Mrs. G., a young female educated upto high school, had left her in-laws' when they came to know of her history of mental illness. This patient had her mental breakdown in adolescence and after recovery

had residual obsessive-compulsive symptoms. The parents got her married in a hury to a family of lower status in the hope that mental illness would be cured by marriage (a local belief). Even the patient felt that her 'bad' ideas (sexual preoccupation that someone would fall in love with her) subsided after her marriage. During the individual therapy the parents of his patient got her divorced from the unemployed husband and kept her along with her young child in a joint set-up, which later led to interpersonal tensions in the family. The eldest brother of this patient remained unmarried and the younger one, soon after his marriage, had to separate due to quarrels between his wife and the patient. Mrs. G. had studied upto high school and it was suggested that she study further privately. She successfully completed the B.A. (Pass) course depsite complaints of poor concentration, anxiety and having obsessive 'bad' ideas. She was also quite busy in taking care of her young daughter and ailing bedridden mother, but described these role obligations as the innermost satisfaction in her life. She felt that her father had never encouraged her in her aspirations during her schooling though she had secured high marks and wished to become a doctor.

Mrs. G. was quite keen to start working after getting her B.A. and several times discussed her plans in the group. Her father did not allow her to start earning even at home as he felt she was economically well provided for and it was against their family tradition. Mrs. G. had a lot of deep-seated resentment towards her father since childhood and behaved at times in a regressed violent manner when her father opposed her. This led to further problems in family life. Mrs. G. beame reconciled to her fate but developed fears in

going out alone even for minor shopping or taking her pet dog for a walk. In the group she was noticed while talking in a loud harsh voice and becoming hostile towards other members if not given the opporunity to express her problems. She was found especially jealous of those female members who were smartly dressed, talked fluent in English or tried to establish closness with the therapist. She was very critical of those who took more time in the group in reviewing their problems. However, when she was given a chance to talk she became hesitant but invariably seemed dissatisified with others for not giving her a patient hearing. In privacy she told a female member that if she talked smartly somebody would fall in love with her. This member enabled her to work through her phobic reactions and brought to the group's notice Mrs G.'s overweight problem and keeping a low profile like that of a Hindu widow. But Mrs. G. could not change and got into a quarrel with her. This made Mrs G. alienated in the group and she preferred individual psychotherapy to group psychotherapy. In the individual session she revealed that an uncle, who later became a mental patient, had sexually abused her in childhood sleeping with her in bed..

4. Ms U., 24 years old, worked as a Senior P.A. staying with her parents. She had an inferiority complex about her dark complexion and shyness as she came from a community where people are of fair complexion and famous for their sociability. She suffered from chronic depression as well as asthma and therefore wished to remain single. She was taken in for individual psychotherapy which was later combined with group psychotherapy. This patient

worked through her problems in the individual sessions fairly well but felt frightened in the presence of group members. In her office she faced a similar problem as she did not want to interact with a large group. She had declined a promitoin offered to her as the senior job would require her to supervise others. She was kept in group therapy to work through her interpersonal problems after a lot of preparatory work in th individual therapy.

5. Mr. K., 28 years and single, had a history of mental breakdown in the final year of an engineering course, but he passed and got a senior position in a government office. He was the eldest son and had four sisters and a brother who were studying. His father ran a small shop. He delayed his marriage due to family obligations as well as a constant fear that the dreadful mental illness might come again. He had also developed some obsessive thoughts and rituals to combat his anticipatory anxiety of mental illness. He felt his work efficiency was deteriorating and he was becoming unable to mix with anyone except his family. He had got into the habit of chewing paper and compulsively collected dirty torn papers from the roadside and kept them in a pocket. He was frightened that if noticed he would be labelled a 'mad person'. He started with individual psychotherapy and after few sessions could bring down his anxiety to the extent that he got married on his own to a schoolteacher.

Soon after his marriage he stopped coming for psychotherapy. After some time he returned, complaiing of problems in his married life as well as in his office due to heightened anxiety about mental brekadown. At that time the therapist was not able to take Mr K. for individual psychotherapy, though the

patient insisted that his problem required psychotherapy and not drugs. He was admitted in the psychiatry ward for arriving at a final diagnosis, which varied from schizophrenia to obsessive-compulsive personality disorder. There was a history of schizophrenia in his maternal uncle and his mother was reported to suffer from chronic anxiety and hypochondraisis. His young wife did not know about his visits to the hospital before their marriage and the details of mental disease in the family. Therfore she was shocked and feeling cheated, was eager to separate her husband from the responsibilities of the joint-family and end his frequent visits to the hospital. These problems became much more acute when she became pregnant and wanted to set up her own housheold and live in a style which they could afford, since both of them were earning. The patient was very keen to discuss his marital and family problems, and at the behest of the therapist had reluctantly joined group therapy.

6. Mr. S.K., 30-year-old government employee, had suffered from a mental breakdown in the final year of a professional course. He felt he never came back to normalcy. He had left his home town in early adolescence to study and had got separated from his parents, although he was the eldest son and the family were keen that he should shoulder family responsibilities.

Mrs. S.K. was living in government accommodation and was earning a satisfactory income. He felt that his professional degree had secured him a job from which he could not be thrown out though his work efficiency was poor and he had been getting reprimanding notes from his boss. His interaction

with his seniors hurt him deeply but he was able to manage such crises in his office by approaching his superior in a tactful manner. Mr. S.K. felt that this was due to his psychiatric problems which had not been properly treated. His medical records indicated that he was treated on schizophrenic lines and had been given several ECTs in government hospital. He felt that ECT had damaged his memory and concentration power and that he was left with no mental energy to attend to intellectual work, though in the field he was able to supervise his junior colleagues. The patient, after two years of individual psychotherapy, was shifted to group psychotherapy.

In individual psychotherapy it was found that Mr. S.K. was living with a male who acted as his passive homosexual partner. He reported tht he got into this practice in his college days and had been moving from one partner to another and even picking up unknown males from the roadside. As he was living far away from his family he could manage these affairs without their knowledge.

Mr. S.K. was brought up in a nuclear family. He had three sisters who were settled in marriage, and his younger brother had discotinued studies due to a similar type of mental illness for which he had also been given ECT treatment. There was a history of mental illness in his maternal uncle, who could never come out after admission to a mental hospital. His mother was reported to be a semi-literate lady, highly sensitive, who had become bedridden through constant worry about her brother and sons. She had also developed a chronic medical disease which was not disclosed to Mr. S.K. The patient's elderly father (he had children by his third wife) was running a wine

shop and was the only healthy member to take care of the famiy responsibilities as well as household work. Mr S.K. avoided visiting his home town because he felt he could not tolerate the misery in the family. He participated from a distance by writing letters or sending some money to his mother for her treatment.

In psychotherapy, Mr. S.K. seemed quite guilty for having developed homosexuality. He reported that he enjoyed playing the dominant role. After a few sessions he expressed his need for the intimacy of a loving partner, which he felt he only got in homosexuality as in his schooldays he had been badly rejected by a female classmate. When he could not get love from this classmate he developed the habit of excessive masturbation, fantasising about the girl. This preoccupation brought a fall in his academic performance and he gradually developed a hatred for females.

At the start of individual psychotherapy, Mr S.K. was shy and wanted not disucss with the female therapist his private life of homosexuality. However, when he was given a couch position, he was able to talk in detail about his failure in heterosexual relationships, which were confined to prostitutes and where he encountered premature ejaculation. This led to his discovery that he was suited for homosexuality. Gradually this patient could work through his deep-seated feeling of humiliation and rejection in love with a girl, but kept a distance from the therapist of dependency and clinging yet suffering (sado-masochistic type of resistance). He was advised to join group psychotherapy and work through his fear that he was an untreatable person.

Even before entering the group. Mr S.K. had started showing his interest in settling down. He had seen a few suitable matches with the active support of his elder sister and brother-in-law, who were highly placed in his community. He had stayed with his sister's family during his professional education and his brother-in-law had helped him toget treated during his attack of mental illness. Mr S.K. had started visiting this family again and felt that he could not get any support from his mother as she was always nagging him to marry soon. Though his father was affectionate and never made demands on his sons, he seemed convinced that both sons had inherited the mental problem and weak will from the maternal side.

7. Mr. R., a medical student, 23 years old, single, was staying with his parents, who were highly educated and working. Though the patient had room in the hostel, he preferred to stay with his parents in order to prepare for the fourth year examination, in which he was failing. He was a good student and had not failed before coming to the mdical college. By nature he was very reserved and liked to read books and even come to the therapy room carrying his medical books. He mostly sat next to the therapist and avoided interacting with the rest of the group. He brought out his academic failure without showing any feelings and in a resentful manner talked of his economical problems with his father, who expected that he should finish his medical education and start earning as he did himself, being a self-made. Mr. R. had one younger sister who also got into medical school, passed out earlier than him and was settled in marriage. It seems the rapid progress of his sister made him alienated to the extent that he came back to his hostel

and started preparing for examinations all alone. His father reported that in the hostel Mr R. was aloof from the surroundings, seldom went to classes and was deteriorating rapidly. However, Mr R. felt very resentful towards his father for coming to the hostel and keeping a watch on him.

This patient's dress and general appearance never gave the impression of a medical student, as he dressed shabbily and was often found with a vacant expression. He avoided eye-to-eye contact while talking to others though he never complained to his psychiatrist of any florid symptoms of schizophrenia like hallucination. He invariably came late or cancelled appointments without giving any prior information. In the beginning the group memebrs were tolerant towards him, knowing of his problems in his studies and his maladjustments at home. His frequent interruptions in the treatment could not enable him to establish interpersonal bonds either with anyone in the group or with the herapist. Continued tranquilliser intake for several years had made him overweight and sluggish in motor activities. He sat through in group sessions as if he was listening attentively to a lecture being given in a classroom. The therapeutical alliance seem unsteady both in individual and in group therapy, but the patient kept coming to the group infrequently because his psychiatrist had referred him for psychotherapy.

8. Miss B., an architect who was unable to get into a steady job due to her psychiatric problems and admission to hospitals in emergency. This case was diagnosed as schizophrnia with suicidal risk. She lacked a proper social support system. Her eldest brother suffered from mental retardation and her father,

to whom she had been closely attached, had died. Her relationship with her mother was of mistrust and dislike which seemed to have been mutual since early childhood.

This patient has been discussed earlier. Her attendance at therapy was irregular. She often demanded individual sessions for self-disclosure of secrets and alientated some female members of the group. She was sociable to male members but nobody could empathise with her when she talked about her impulse to commit suicide or giggled ike an immature girl while saying or listening to serious matters.

9. Mr. S.N., 26 years old, single, unemployed, represented himself as busy looking after legal suits related to his father's property and writing work. His father was a renowned scholar who wrote several books and after retirement had developed sudden blindness. The patient was the youngest son among seven siblings. His eldest brother had separated from the family soon after his marriage as his wife could not adjust in the joint family. His three elder sisters were married and two were unmarried. The father was described as a self-made man who had amassed property and had taken his reputation to a height which none of his family members had attained. The mother was described as coming from a family who were in the legal profession or big businessmen. She was a practical down-to-earth woman and family responsibilities were usually shouldered by her.

Soon after the individual treatment of the patient, a mishap happened in his family. An unmarried siter committed suicide, for which Mr. S.N. openly held his father responsible. He had a murderous rage

by observing how these vary over a period of time and changes revealed by verbal (speech tone, pressure, content, etc.) as well as non-verbal expressive behaviour (gait, gestures, dress, facial expression, postures, mannerisms). To the psychoanalytically oriented group therapist this assumption looks overly simplistic. For each of the patients described above, who were suffering from psychiatrically diagnosed diseases and referred to group psychotherapy with adjunct drug treatment, the threapist evaluated a baseline measure of typical intensity level through a detailed case history and individual sessions with the patient and family members. The question was whether the overt intensity (increase or decrease) is beneficial or detrimental or of no consequence in a group process working at a mature stage. The diagnostic formulations made by psychiatric colleagues were found extremely important in determining whether or not a speicfic intensification of behaviour in the group was therapeutically beneficial or harmful. Thus, for example, increased emotional expressiveness might be highly desirable at this mature stage of group therapy: but the therapist must differentiate significant changes in intensity level (verbal and non-verbal) which are attributable to current state of psychopatholgy or interpersonal conflict within the group process or are culturally determined styles of expressive behaviour of transference reactions with the therapist or among group members. Each change in overt intensity should be gauged by how the patient is trying to affect the therapist and group members. Viewed in this manner, sizeable changes in intensity may be of little significance, whereas certain changes may be of considerable dynamic importance.

> To illustrate this point, we take the case of Miss B.'s behaviour when she entered the therapy room quite late and announced suddenly that she had come to take the permission of the therapist and other group

members to commit suicide. She had made this announcement in a matter-of-fact tone yet giggled about it like a young child (a form of behaviour often seen among schizophrenics). At that time the whole group was in a jovial mood, hearing about another member's childhood pranks. The members directy were not involved in Miss B.'s decision-making prcoess, which changed the mood of the patient for some time and made her interact with others as if that was her private affair and she had a right to do what she pleased. But the therapist, knowing the detailed history of this patient, was seriously concerned about it.

Miss B. had been admitted in the psychiatry ward after a suicide attempt as a serious medical emergency. She had tried on several occasions to go to the top floor of the hospital to jump but was prevented by the treatment team. In order to prevent a similar occurence the therapist asked the members to take Miss B. along with them to the hospital canteen (it was on the ground floor). In the ordinary course the therapist would not have allowed this, but knowing that the patients would be visiting the canteen after the session, the crisis management technique of engaging the peer-group was utilised. The therapist also gave Miss B. an extra appointment for an individual session along with her mother to evaulate her impulsive acting-out behaviour due to the lack of proper social support or due to acting-in of a transference relationship. In subsequent group sessions, Miss B. did not announce a suicidal impulse and her intensity level in terms of social interaction with the group members changed. Probably this was due to the therapist's ability and timely action taken to involve the family member in the management

of this patient. In the traditional Indian family a girl's dealing with a strong emotion in a dramatic manner is never approved of. Miss B.'s poor impulse control due to the psychopathology of a disease process resulted in unihibited behaviour which bewildered her family, colleagues at work, treatment team in the hospital, and now the group members. In individual session it was evident tahat her intense behaviour required listening with empathy to the painful psychodynamics of this patient. Since childhood Miss B. could never get along with her mother, who felt that the girl child ws not learning any domestic work and was being pampered-by her father. Miss B. had a dark complexion and was openly ridiculed by her mother. At times she was driven into the kitchen to learn domestic work, whereas her father encouraged her to pursue higher studies as a result of which she became an architect.

Unfortunately her father died when this patient was in her professional school and her parents were living abroad. After her father's death, her mother could provide economic support but could not appreciate her higher education. Relatives constantly advised the mother to get Miss B. married soon. The mother tried her level best to find a suitable match for her daughter, but she could not give a large dowry and found that the girl's dark complexion might make it difficult to arrange her marriage within their community. The mother despaired and the patient became more hostile towards her. A time came when the patient felt compelled to leave the family and stay all alone in a 'barsati' while in search of a suitable job.

The stressful sociodynamics of this case, along with some intrapsychic conflicts of the patient which were

revealed to the therapist later, might have precipitated in group therapy. It seems her mentally retarded elder brother tried to molest her during adolesence. The patient at that time was living with her grandparents, her parents being away in a foreign country. When the mother came to visit them, she could not understand the deep hurt feelings of her daughter. Instead, she reproached her for not being able to take care of herself especially when she was getting into womanhood and being given so much education. From that time onwards, Miss B. felt distant from the mother and never trusted herself with either her monther or her elder brother. She began to form a wall between herself and the outer world. She was close only to her younger brother, towards whom she had a sort of maternal attitude. Since childhood the patient and his brother had stayed back in India and felt jealous of the elder brother, whom the mother took abroad and whom she was always over-protecting as he was the eldest son.

After the revelation of this in individual session Miss B. was seen increasing her non-verbal communication in relation to verbal, especially in the group while interacting with educated male members. A female member in the group often objected to Miss B.'s late coming and frequent missing of appontments. The other members in the group were sympathetic towards her and listened with empathy whenever Miss B. talked of her struggles with her life situation. She gradually started speaking of her thoughts, feelings and actions in respect of current life situations and never opened up her historical material or suicidal impulse in the group. But she invariably aksed for individual psychotherapy and whenever she was given extra

appointments for individual sessions, she started showing resistance by decreasing her intensity level of communication. She would look at the therapist with her eyes wide open and when asked what she wanted to say, she would smile and at times murmur that she had nothing further to tell and felt satisfied at being understood by the therapist. In a subsequent session she brought out her resentment over her love affair with a young colleague as well as the hurt feeling of being cheated by a highly manipulative boss. The therapist had no access to the reliability of this information, but after a considerable period of interruption of treatment (both individual and group psychotherapy) saw the patient brought to the psychiatric ward within a psychotic breakdown. In this re-admission, the patient had developed frank delusions and was therefore placed on psychotropic drugs. After discharge, she was advised to see the therapist, but she could not be motivated to join group therapy. The therapist was reluctnt to give this patient individual sessions, knowing her current psychopathology and the poor social support system available to her; and also at the time had no open hour to give her time for individual psychotherapy.

Miss B. came for a few sessions of group therapy but was found becoming incrasingly allergic to intense feelings in other members. She tried to avoid participation in the group, either coming too late in the session or not coming at all for several sessions; and later she dropped out of the group. Whenever she came for psychiatric consultation, she made it a point to enter the therapist's room even when the session was going on and the door was closed. Even for her psychiatric check-ups, Miss B. visited only one

psychiatrist and preferred to go without any follow-up rather than meet a new consultant. She made demands on the therapist to be given individual psychotherapy, but when the therapist gave her an appointment she never reported. Thus the therapeutic alliance could not be established and often the patient visited the therapist in a casual manner and was seen becoming dis-organized (shabbily dressed and looking lost in her thoughts). When asked in an informal manner about job or family she reported that she was still unemployed and her family existed for her only in crisis situations. She said that she had been regularly going to her previous work place to meet the man whom she accused of having had an affair with her, but whenever she talked with him about marriage he was evasive and lately had started avoiding her. She said that the people there made fun of her whenever she directly asked about the whereabouts of her friend.

In this case, changes in intensity level had occurred and acting-out behaviour had followed. There was healthy improvement for some time but later a decline, probably due to interruption of psychotherapy, medical non-compliance, as well as the lack fo social support system. The anxiety of this patient manifested itself whenever the overall intensity of the group reached a critical level. One can assume that a primary cause of change in intneisty level is the eruption of impulses and associated fantasies as a result of one or more of the following : (1) spontaneous self-revealtion; (2) therapist's elicitation; (3) loosening of defences by the therapist and group members; (4) participation in group resistance; (5) multiple transfer reactions to the therapist and other group members; (6) identification with others in the group; and (7) the clinical course of the disease process.

The second cause of changes in intensity level is the

coming closer to consciousness of non-conflictual impulses and fantasies. This produces pleasurable excitement with little or no concomitant anxiety. This situation is complicated in the analytic group becaue the patient's thoughts and feelings at times are not conveyed in words due to cultural pressures of disapproval. In Indian culture, intimate feelings and strong emotions associated with sexuality and aggression are not expressed in words but through non-verbal cues. The group therapist is required to observe, through non-verbal cues, whether the gratifying excitement and pleasure of instinctual drives is being communicated by a member in the group all alone or whether this is a resultant pleasurable excitement shared by others members getting further enhanced by excitement over the help one has received in a well functioning analytic group. To illustrate this point, we take the earlier discussed case of Mrs P., who seldom talked of her marital problems in the heterogeneous group setting but conveyed sexual dissatisfaction through subtle non-verbal cues such as gestures and dress. Though the male members of the group spoke frankly of their psychosexual problems, this patient could not put in words her husband's psychosexual inadequacies though she showed minimal defensiveness and transferential distortion. Her behaviour in the group could be characterised as a genuine cathartic expereince, and male members were encouraged by her probing non-verbal signs to reveal their sexual concerns. Mrs. P. desirbed her intense emotional reactions in the following dream.

> I had gone to purchase a mixi. The salesgirl shows me one but it is manually operated. I want to buy an electrically operated mixi. The salesgirl convinces me that this manual one will function better, so I buy it and come back.
>
> I am in my parents' house and see that everyone is enjoying a meal in a festival mood. My childhood

> priest (who had got me married) asks me to get some more hot 'puris'. I gladly go and bring them for him. I see a very big oven burning and around it there are several men preparing and frying 'puris'. I become startled and suddenly I hear a loud noise coming from our provision store-room. We all rush towards it. Suddenly I see a long corridor with cobwebs. I enter it, although inside I am afraid. I never used to enter the store-room alone because big rats used to run about. Something kept following me in the passage, and in the end, I find a beautiful statue of Goddess Durga. I am very excited seeing her benevolent expression, but I wake up.

This brought a valuable breakthrough in Mrs P., probably becaue it brought to her consciousness her childhood anxiety-laden responses to the complex stimulus situation of the group. This patient seemed to have a need for close personal contact with the maternal figure. Because of the prolonged illness of her mother this patient had to assume very early the role of an adult female to look after seven younger siblings. Perhaps there was a precipitation of separation anxiety and competitive feelings towards male members, who were seen as siblings, but she was not abe to work it through until this dream was reported. It was as if the long process of psychotherapy (individual and group, already taken for two years and viewed as a corridor full of cobwebs) was frightening. However, her courage to go on had brought a self-revelation in the form of a goddess who in India symbolises power over men of women, good and evil, and who bestows prosperity on family life.

> When the therapist asked Mrs P. what was happening in her day-to-day life which had made her have darshan of the goddess in the dream, she smiled blushingly like a newly-wed and said. 'My family life is happy after a long time. My husband has got a promotion

and we might be moving soon. In the past he turned down his promotion because we would have to move out of Delhi and that would have interefered with my treatment. But since I am feeling all right now, he might accept the offer.' Although at this stage of therapy the therapist viewed this patient as unable to address some of her long-standing neurotic conflicts, the group (including the patient herself) felt that she had been successfully treated by group psychotherapy.

Mature Phase - role of the Therapist

The analytically oriented psychotherapist utilises a wide variety of techniques to achieve optimal intensity in her group. Especially when working with psychiatrically diagnosed patients, psychoanalytic interpretations are avoided until the patients have developed sufficient ego strength and have learnt to use the group effectively. As in individual psychotherapy. the technique in the group also is first to strengthen and support the patient's ego. then to elicit the underlying conflictual material, and finally to enable the patient to work-through this at his own speed so that he understands and gains control over conscious conflicts. In this process, it is of the utmost importance that the therapist detects her own counter-transferential reactions and deals with them effectively.

The doctor-patient relationship is complex, compounded by a number of cultural, social and personal interactive factors. The dynamics of therapy of an individual, a family or a group requires the therapist to act in such a way that new expereinces will be helpful to the patient; although this is not the case in begining of most diseases of psychiatry. Here the chronic course of various diseases is due to multiple etiology as well as the sequeale of various other factors. Knwoledge of this, especially when the patient has been labelled after thorough

investigation by an expert team of medical colleagues in a teaching-cum-research centre like AIIMS, leads to certain logical considerations in the mind of the psychotherapist about the prognosis of the case. Will psychological methods of treatment be effective? After interviewing the patint she decides whether psychoanalytically oriented psychotherapy is worth trying in the case, which largely depends on her gut feeling of whether or not she can get along with the patient.

On the other hand, during the long process of evaluation, the patient has waited and debated about his chances of recovery as well as whether this the best place to get treatment. After he enters psychotherapy, if he is unable to address his heightened anxiety, as well as counter-transference reactions are created in the therapist. Especially with medical students or doctors as patients or their family members, there is a likelihood that when they are not sure about the diagnosis they consult various textbooks of psychiatry and develop hardened attitudes towards their chances of recovery. In treating such patients in psychotherapy of any form, the issues of counter-transference and transference reactions seemed by and large induced due to iatrogenic factors in the analytic setting. Thus the patient, the psychotherapist and the group analytic setting, all three may contribute to and effect the therapeutic alliance. The following case of Mr R. in group therapy is illustrative of this important issue of counter-transference.

> Mr R., being a medical student, knew his diagnosis and had read thoroughly about the line of treatment and prognosis of schizophrenia, though when he entered group therapy he had no florid symptoms of the disease. The parents of this patient and his sister, being highly educated, knew the chances of recovery but were reassured that the treatment team felt differently about this patient's recovery than what was written in the text-books. However, the family

dynamics of this patient complicated the analytical setting.

Mr. R.'s father was directly approaching the treating psychiatrists and was becoming quite disappointed with the long process of psychotherapy. He had left his joint family soon after completing his education and beginning to earn independently, though he belonged to a caste (Agarwals of Haryana) where jointness is well maintained. He was finding it very difficult to look after his son's prolonged treatment and saw him as a burden on him. He often compared is son's peformance with that of his relatively bright daughter, who had completed her medical education and got married during the long period of her brother's treatment. He openly scolded Mr R. for his academic failure.

The strongly expressed emotions in the family made the patient aloof and alienated. He expressed his deep resentment to his mother by the passive aggressive behaviour of not eating, not talking to anyone and siting alone in his room. In therapy he had shown a greater need to belong to his grandfather and uncle (father's elder brother) than to his own parents. As he grew up he felt that his parents did not approve of his attachment to the extended family on account of a property dispute with them. His father was also found to have an ambivalent attiude towards his parents and was not willing to accept certain social obligations towards his aged father as he felt he was a self-made man. The father expected his son to follow in his footsteps and often angrily asked the patient to leave the house and live in the hostel to make himself a successful doctor. When the patient left the house and started living alone in the hostel, the father felt guilty and started meeting his teachers to ask about his prgoress. The patient felt deeply hurt on the grounds that no other fathers visited their sons in the hostel or met their teachers in this way. The combination of overprotectiveness and rejection

made the patient quite confused, and he viewed himself as being unable to meet the high expectations of his parents.

Due to urbanisation and industrialisation there is rapid social change taking place in India. The most significant changes are seen in the transition from the joint family system to the nuclear family unit. It is hard to define these two terms, as different social scientists, depending upon their orientation, view the problem in specific perspectives. In the current Indian scene most families seems to fall somewhere in the middle, and the tem 'extended family' is being preferred. Kapadia (1966) feels that even if there is an expressed desire on the part of some to leave joint households and establish nuclear units, this is not an 'unequivocal desire'. The younger generation, though seen complaining about the suffocating atmosphere of the joint family, at the same time appears to be conscious of certin benefits to be derived from joint living : economic help, refuge in crisis situations, proper care of young children, restraining influence on clashes beteen hsuband and wife, and so on. In short, the joint family system is still largely viewed as being better able to meet people's needs than the nuclear set-up.

In clinical expereince we often find people who are psychologically not prepared to break away from the joint family, and this seems to be corroborated by the writings of some Indian social scientsits (Gore 1968, Kapadia 1966, and Ramanujam 1971). They have emphasised that while structurally some changes are taking place, attitudinal changes do not keep pace. According to the Hindu Dharma, an individual is expected to perform assigned roles in the family hierarchy and fulfill his obligations, and there is little recognition for the individual's aspirations and needs within marriage. As Hoch (1966) puts it.

"If we look back on the old pattern of the joint family

it may seem as this ideal had been realised to a remarkable extent. The tolerance in a joint family for deviations and accentricities, even for outright illness in one of its members, is indeed often astonishing. But is this tolerance really what we would understand by the consciously cultivated virtues of grace and forgiveness? One may have one's serious doubts about it."

From this one may infer that the group members tolerated the eccentricities of Mr R. and contained him in the therapy group not out of a consciously cultivated virtue of tolerance but due to their socialisation process of loyalty to family solidarity. There was an appearance of personal relationship as well, since in group therapy Mr R. had the prescribed membership status. But in terms of functional meaningfulness there was hardly any interactional communication in the group process. Mr R. came to the group as and when he liked. Nobody objeted to this, probably due to his special status as a medical student. In the beginning he felt secure and comfroted in the group but gradually was found lonely and isolated. Probably due to his schizoid personality he felt there was nothing common beteen him and the group members and viewed the group members like his own family, who expected him to pass the medical examination and become a helpful doctor. His frustration was inability to come up to their expectations, and this estrangement was discouraging to the therapist, who in her ong career had seen several patients who, if properly treated, were able to continue their higher studies after having a psychotic breakdown.

However, in the case of Mr R. our treatmet team could not enable him to regularly attend classes and appear at the examination. Probably the noconfromist attitude of this patient signified a deeper personality disorder than a disease of episodic nature. He showed a child-like dependence and

hunger for love in the individual sessions but in the group setting became aloof and distant. He could not accept the social obligations and norms set for him by his family or in group therapy. The group initially gave him the special status of a bright medical student who was caught up in difficulties of study. Later, whenever any member of the group asked about his study problems, Mr R. evaded by not establishing eye-to-eye contact or by replying in monosyllabies. Mrs L., a female member, while discussing her own anticipatory anxiety about her forthcoming examination, once confronted Mr R. regarding his plans of appearing in the examination. This made Mr R. quite resentful in the group. He immediately left the therapy room and was brought back to the session by the persuasion of the therapist. The pressure built up by the group member seemed an unberable strain on him, which became evident when in an extra individual session he revealed that his father was pressurising him at the time to appear in the examiation and had visited several teachers in the medical college requesting that his son be given special coaching and individual attention so that he might clear some of the subjects. Mr. R. was quite keen to discontinue group therapy at this stage and wanted to devote all his time and attention to his studies. The therapist felt that strong expressed emotion and direct confrontations in the group would lead to further frustration and guilt feelings in him. Therefore he was advised to continue his medication and follow up with the psychiatrist only.

Mr R.'s sudden separation from group therapy did not entail any bitterness or remorse among group members : rather, they felt that he needed to pay serious attention to his studies. The group process evidently had the potential of creating serious conflicts in Mr R., although group members had showed tremendous tolerance towards his deviations and accentricities. This might have been due to loyalty to family

solidarity. However, the departure of a family member for personal growth was viewed as a solution by the group members.

In the Indian culture, the greatest good is of greatest numbers. Thus, whenever the prescribed mode of social interaction is disturbed, the individual member is perceived abnormal as a person who acts as he or she likes. It is not uncommon to find such family tensions leading to suicidal attempts by vulnerable individuals who find it difficult to meet high family expectations and in whom guilt turn into self-hatred. Often the suicide attempts seen in clinical practice seem to be cries for help and intended to make elders realise the effect of their constant nagging and pressure.

In psychotherapy such individuals show early improvement in their mental health due to positive transference towards the therapist. However, they project on to the therapist their own fantasies of omnipotence. They fear the therapist's omniscience, for they are afraid that the therapist will come to know their hidden secrets. Constantly frightened by this possibility, they may prematurely break off psychotherapy after showing what is commonly called a transference-cure. Such patients often come back, usually with a severe attack of depression.

> Orally regressed patients feel unloved and want love, as Glatzer (1965 page 170) aptly describes it : 'Inability to get through the pseudopositive transference, which is a superimposed defence on the negative transference, keeps intact these negative projections. The unconscious fear of the analyst as a predatory parent figure by an orally regressed patient makes analysis of his positive transference an arduous (and) too often a hopeless task. He denies all negative feelings to the therapist but continues to cling to the passive,

> camouflage love with its concomitant resistance in the form of sticky dependence'. In group therapy there are opportunities to cut through this pseudopositive transference.

In the psychoanalytic literature it is said that the inevitable frustration in the oral phase makes orally regressed patients project their hatred of childhood restrictions onto the mother. This is the source of the pre-oedipal fantasy of the 'bad mother' which is observed in the superego and then turns against the ego in the form of masochism, guilt and depression. In group therapy other members usually perceive through the pseudopositive transference facade and pick up and react to the underlying hostility of such orally regressed patients. In the group the patient is less afraid to express his anger and his negative reactions. There is general agreement among group therapists that transference is a major vehicle of treatment in psychotherapy and the matrix of all other therapeutic dynamics. Therefore in the mature phase, where the working through is an essential goal of the therapeutic process in the anlytic setting of group therapy, those of us who practice both individual and group psychotherapy pay special attention and laboriously go over and over again the interpersonal interaction taking place in 'here and now' situations. As Greenson (1965) has emphasized that, the working through process is a continuous attempt to transform intellectual insight into affective understanding by resolving resistances which impede insight from leading to significant and lasting changes. However, the transition from intellectual insight to genuine change in feeling and action is difficult to achieve even in the regulated mature phase of therapy. Why it is so will become clearer with the followng case illustration.

> In individual psychotherapy Mr K. had shown a rapid improvement and had formed with the therapist a deep attachment, respect and a symbiotic mode of

relationship. The closest he could come to negative transference at the time was in perceiving the therapist as too busy with other patients. After the interruption of individual psychotherapy, Mr K. maintained healthy improvement for some time. He settled in marriage and was blessed with a child. When he returned to psychotherapy he emphasised that he was happily married and leading a very peaceful life, yet felt unhappy that professionally he was not getting any recognition due to his own lethargy and poor output at work. For his low energy he held responsible his past breakdown and the constant anxiety in him that one day he would have another mental breakdown. The patient was reluctant to join group therapy. but at the behest of the therapist came in and expected this time not only to become the therapists' favourite but also that of the whole group.

In the group there were several other professionally competent member like him who showed strong transference reactions to this new member's entry. Mr K.'s keen competition resulted in a spontaneous erruption of primitvie rage. Mr. K. was pressurised and even ridiculed by them and nicknmaed an 'old man' and a 'philosopher' when he showed the ambition of becoming a leader and also discussed his own adjustment problems with them. One competitive male member perceived this need intuitively and accused Mr K. of having marital problems which he was not talking about. Mr K. laughted at this and said he was like a lotus in a pond. He started avoidng the male members by not joining them for refreshment after the group meetings or by not coming for the open sessions (the group met once a month without the therapist). Whenever any member made provocative

remarks he failed to respond. He was equally distant with the female members and maintained from them the traditional curtain between male and female privacy. The female members did not like his role as an orthodox rigid married man, since others in the group were friendly and interacted with them.

Mr K. wanted to engage himself in a meaningful social relatinoship and become a leader but did not know how to do this. His regular coming to the group helped him considerably and evoked a desire in him to know how other people felt about his personality. The therapist understood that there was gradual accumulation of regressed anger in Mr K. which he was turning into invert aggression, but did not know until later that this patient was sharing his hurt feelings with his wife. with whom he had formed a symbiotic relationship. One day wife (Mrs. K) appeared abruptly in the group therapy session and started accusing the therapist of keeping her husband in treatment when nothing was wrong with him. His wife's attempt to interfere in the treatment and her disturbing the privacy of therapy evoked angry feelings among memebrs. Everyone thought it was breaking rules and an imposition. But this growing irritation in Mrs. K. was perceived by the therapist as a sign of disillusionment and dissatisfaction in marital life.

Soon after this incidnet Mr. K. became unusually quiet. restless and fidgety in the group. He requested an extra individual session and expressed profound regret for his wife's behaviour. He talked in tears of how his educated earning wife had started looking down on his elderly semi-literate parents and wanted to set up an independent household. His younger brother had already moved out of the joint house due to

tensions. Mr K.'s attitude towards his wife was evidently ambivalent, although the relationship between husband and wife had another dimension which requires to be understood to comprehened the rapidly changing social scene in present-day India.

Traditionally, when a bride joins her husband's family, she is expected to almost merge her identity with her in-laws' family. Now we find that wives expect to establish their own households according to their own individual needs and aspirations. This leads to frustration among working women, as happened when Mr K.'s wife wanted to have her own household and bring up their young child in her own style. Mr K. reported that his wife felt that he cared more about his parents than about his own child and that he was gradually becoming more attached to the therapist than to her. With increasing consciousness of women's rights, role and status the modern women does not accept tradition passively (see Kapur 1970). Therefore Mrs K. could not hold herself back and came to grop therapy to claim her rightful position.

Mr. K.'s conflicts of divided loyaliteis and unconscious impulses, though revealed relatively early in group therapy, were not getting worked thorugh. Probably this intrapsychic tension was creating a tremendous anxiety inside him, and he voluntarily sought hospitalised psychiatric treatment in order to be properly investigated. On the advice of his treating psychiatrist all his previous treatment was stopped and he was referred for further investigations, diagnosis and treatment.

Impact of a new entry

The introduction of a new member into a group in the mature phase, as emphasised earlier, brings out a large variety of reactions and deepens transference reactions when a new member becomes a convenient scapegoat by virtue of an exasperating characteristic. It leads not only to an

intensification of the working through process in other members (where the gap between emotional insight and action seems bridged), but in addition the group process looks like a playground for rehearsing the family drama of rivalry between siblings, first cousins and distant relatives, who require to be given warm hospitality yet cannot be allowed to stay on forever in the group. The following case examples are illustrative of this.

> Mr. S.K. was convinced that ECT treatment had permanently damaged his memory and concentration power, though he had sufficiently worked through his problem of homosexuality and was ready to marry a suitable match. In the group he often narrated in detail his frequent visits to see prospective brides and openly expressed his wish that the therapist at this stage should actively participate in choosing the correct partner for him. The therapist, knowing his dependency needs (which were continuing at the age of nearly 35), allowed him to express freely his deep-seated resentment towards his parents (in the Indian set-up it is generally the parents who provide help in finding a vocation and a marital partner) as well as towards the therapist. In the individual sessions Mr. S.K. had often talked about his dislike of his bedridden mother and his passive father. He felt that his father always took the side of his emotionally unstable semi-literate sick wife, no matter how irrationally she demanded that the son marry soon and give her a grandson. According to Mr S.K. his sick mother's constant nagging on this issue was like a hanging sword on his head. In the group Mr S.K. brought out his frightening dream in which he saw his mother on her death bed when suddenly she came alive and turned into a ghost. After narrating the dream, instead of associating on the dream content, Mr. S.K. along with

some male members made fun of his mother.

This annoyed Mr. A., who had recently come to the group after long individual psychotherapy. Mr A. had a psychotic breakdown when he had gone to pursue a professional course far away in South India. This mishap led to the discontinuation of his studies. His father was semi-literate, running a dairy business, his eldest brother was in government service and the younger brother was helping their father. The mother of the patient was a semi-literate housewife and his sisters were happily married. Mr A. lived in a joint set-up.

In the initial stage of individual psychotherapy, Mr A. kept silent most of the time and refused to relate his history or day-to-day residual fantasies, etc. He kept repeating that he had only the single complaint of sleeplessness. At times he shouted at the therapist when she probed into the current or the past, but he came very regularly for psychotherapy appointments and reacted sharply to minor interruptions made by any outsider in the analytic setting. His aggressive outbursts as well as rivalry suggested that group psychotherapy might benefit him.

When the patient came to group therapy he was idle at home and at times was brought by his father. However, he gradually started coming alone and became socially interactive. Group members had observed his dependence on his family, and therefore when he reacted aggressively to Mr. S.K.'s 'loose' talk of his mother, the female members joined to support Mr A. There was heated discusion in the group on the issue of loosely talking about mothers, but Mr S.K. along with a few others insisted that it was just

light talk and that he had no intention of hurting anyone's feelings or of demeaning the high status of the mother. Then the group started talking about the dynamic Prime Minister, who was a lady respected by all, and Mr A. was directly confronted by Mr S.K., who said, 'It is high time you came out of your mother's lap. You could not separate from her and that is why you ran away from the South and came back to her'.

After this there was a rapid change in the behaviour of Mr A. He reported that he now went to sell newspapers in a busy market in order to earn some money to support himself. Earlier the therapist had dicussed with him how he might improve his daily living by helping his father or by getting work which would keep him occupied. However, Mr A. had not shown any initiative to start work. He also brought to the individual session a vivid childhood memory of primal scene and felt, seeing that he disliked his father for having sex with his mother, (who was described as a very pious lady.)

Mr A. started opening further in individual sessions and said that he had no sexual expereince except for a humiliating espisode during his adolescence (another boy had forced him into a homosexual act which resulted in a flight from the scene). He had strong guilt feelings about occasional masturabation and said he liked to conserve his sexual energies for study. He added, however, that his younger brother was to get married and that he was conscious that all the males in his family were enjoying happy sex lives and having children while he was studying. He was the only one in his family who pursued higher studies, and he was especially indebted to his mother, who had sacrificed

a lot in running a joint family where extended family members came and stayed for long periods. Mr A. was very fond of his mother and described her as a tolerant and god-fearing person. He felt that his educated sisters-in-law often dominated his innocent mother. he also seemed to have an ambivalent attitude towards his mother for not having her own say in family matters. Since his father was a very authoritarian type he felt distant from him.

Gradually Mr A. started distancing himself from family affairs, completed the B.Sc. and M.Sc. degrees, scuring high marks, and began research work towards a Ph.D. while in psychotherapy. At this time he was being prepared for the termination of his long-term treatment. His father died suddenly after a breif illness. This led to serious emotional problems and turmoil in the joint family, which especially upset Mr A. He was becoming insecure about the status of his mother and his own as a bachelor in the joint family set-up, where they were given a single room to share on the terrace. Mr A. felt that he could communicate well with his mother but did not know how to get her rightful palce in the family. He started turning to the outisde world and showed an active interest in his colleagues. However, his outside interaction tended to show him that he was a socially handicapped person. He started feeling jealous and competitive towards male colleagues and was humiliated by a female colleague whom he approached with tender feelings. These failures made him pay serious attention to his research work, and with the active support of his guide he wrote a research paper and presented it at an international conference.

Afte this Mr A. began to look quite confident and at

times even elated and dominating. He started feeling that he was the favourite student of his guide and that others should give him special privileges. In the group he startd acting as if he was the patient most loved by the therapist. One day he took out a female member and proposed marriage (breaking therapy norms). In the individual session he reported that he was deeply in love with this newcomer to the group as he had always admired her while waiting outside the therapist's room. However, the reaction of the female member was flight from group therapy. She did not mention this matter even in her individual session and was in a hurry to discontinue treatment for fear of losing her anonymity and also on the pretext, given over the telephone, that she was to get a promiton in her job so unable to take off from office.

After this acting-out Mr A. showed a steady decline in his research work as well as in psychotherapy. He had fights with male colleagues at his research laboratory and in a fury slapped one of them. His research guide was surprised, and since he knew that his student was in therapy, asked the therapist about the reason for this sudden decline. The therapist, in order to provide a quick testing with reality, involved the patient in a discussion with his guide by giving them an appointment together. He was found to have developed mistrust and to have adopted the rigid stand that he should be allowed to condut a series of fresh experiements in order to finalise his work. The guide felt that this was not feasible as work on the thesis had reached a point where it could be submitted without fresh experiemental work.

Mr A. was told to continue this work at the post-doctoral level but he felt that his creative potential

was being curbed by his guide and by the higher university authorities. He started sending them long letters and notes of protest. One day he came to the group and announced that he had abandoned his Ph.D. work (such decisions usually were required to be discussed in therapy) and that henceforth he would devote all his time to getting justice from the authorities and his guide. One of the female member of the group, Mrs G., had a kind of elder sister's attitude towards him (they used to fight with each other like brother and sister). She was quite upset on hearing this statement. The group discussed at length Mr A.'s mistrust of his guide, whom he had earlier respected deeply, and advised that he should submit his thesis and only then begin legal proceedings. However, nobody, including the therapist, could persuade Mr A. to change his plans, and he expressed the view that it was best for him to leave the treatment and devote his time to fighting with the higher authorities at his university.

The follow-up notes showed that Mr . came at times to O.P.D. for psychiatric check-ups and was treated on the lines of paranoid schizophrenia. Later he was admitted in our psychiatric ward as a non-cooperative patient who had stopped eating and talking. His family were quite supportive in providing him the best availabe treatment, yet he maintaiend a prolonged silence and passive aggressive attitude towards them and towards the treatment team. His mother now acompanied him as his father used to do in the past.

Mr. A. maintained a distance form the psychotherapist whenever she met him in the hospital by chance. But after some time the therapist received a frantic telephone call from him, made from a private nursing

home near his house, where he had been admitted in emergency. He started crying bitterly and wanted immediate help. At this stage the therapist was helpless but contacted the treating physician to provide the necessary help. He was at that time admitted in intensive psychiatric ward therefore provided only drug treatment.

Mr A.'s case shows that becoming a schizophernic is essentially a 'social and interpersonal process, not an invitable consequence of primary symptoms and neurochemical abnormality' (Estroff 1989). The recall of the primal scene as well as the acting-out of the incest wish in psychotherapy (scene in adult life) too have complicated the terminal phase of psychotherapy. Social scientists are currently being pressed by the legal and scientific communities to provide more definitive explanations of the disturbed memory process observed in psychitric patients. Several theories such as those of defense repression and dissociation are thought to account for the amnesia that exists in individuals who have multiple personality disorder (MPD). Currently autobiographical memories research findings suggest that patients with alleged histories of trauma have a measurably different pattern of recall of early events. This research (Parks and Balon 1995) suggested that external factors influence memory processes to the degree that some cognitive processes are slowed down, the accessability of information is limited and the range of years from which one can draw information is restricted. And if memory processes are impacted early in development and if the affects are stable over time, extending into adulthood, it may be reasonable to speculate that the memory deficits observed cannot easily be ameliorated by psychotherapy.

Multiple transferene issues

To the same group later came Mr. L.C., 48 years old,

a lawyer, married with two children and recently separated from a large joint family. He projected his sibling rivalry on Mr S. N., who had been in long-term treatment with the therapist both in individual and group psychotherapy. Mr. L.C.'s frequent MDP attacks had been treated with appropriate drugs plus lithium maintenance for several years. However, he was advised to try group therapy by his treating psychiatrist. He entered group therapy in his hypomanic phase. He got quite annoyed when Mr. S.N. talked in detail of his nursing work and care of his aged and ill mother, who had to be taken to various places for laboratory investigations. These patients from the start had got into an affectional bond, since they had similar socio-cultural backgrounds and family dynamics (the fathers of both had high status and after thier death had left their sons to shoulder family traditions and the responsibilities of looking after property, educating and marrying younger siblings and caring for their widowed mothers). Mr. L.C. in this session was prepared to throw Mr S.N. out of the group by verbal assaults. He criticised him and made fun of him, saying that he was extremely dependent and still a child to his mother and now to the thrapist, and that he would never leave psychotherapy at this rate.

It was quite evident that Mr L.C.'s outburst was negative transference and sibling rivalry, which later he could work through by catharsis of his pent-up emotion from his joint family. He started talking of the behaviour of his younger brothers in matters of property as if they were step-brothers acting like psychopaths, and of their mother taking the side of the youngest sibling. He expressed in interaction with

Mr S.N. his own self-emptiness, which was reinforced during his childhood by his father and some close relatives. He had a longing for good mothering. He had been a favourite of his grandparents and had been distant from his parents, who viewed him in turn as a spoilt child. A sense of value and importance was enhanced in Mr L.C. during group interaction, though his mood swings continued during treatment. However, he humoured and advised other members instead of becoming irritable or placating. Though Mr S.N. was able to gain insight into the transference reactions of Mr L.C., he did not verbalise this and started working towards termination of his treatment.

Mr L.C. in his prolonged phase of normalcy met with an accident in which he broke his leg and could not attend group therapy. Mr S.N. went out of his way to visit him and consoled him by making a long-distance call. After his recovery Mr L.C. rejoined the group but seemed in a depressive phase. He complained of sleeplessness and lack of interest in life and was apprehensive that he would not be able to come out of depression. At this stage Mr S.N. as well as some other members were quite supportive and made disclosures about their own past mental anguish. This enabled Mr L.C. to come out of his depressive phase more quickly than ever before. He was particularly satisifed with his new philosophy of life, which was not to resort to a sick-role under the adversities of life. He kept coming regularly for treatment despite a busy schedule as a lawyer and a social worker like his late father. On the other hand Mr S.N., who hd been in psychotherapy for a long time, seemed to gain only intellectual insight and at this stage showed some changes in behaviour. This patient as well as

afew others who had been diagnosed as suffering from schizophrenia, in psychotherapy of long duration showed better ego functioning and mastery over reality testing but dependency in treatment. They were found well adjusted in personal care and some family role-obligations, but a masochistic pattern of repetitive, passive, self-defeatng behaviour was entrenched. Their old hurts and traumas were still vivid even though the duraiton of the reliving of such experienes (in terms of phases of illness) was shorter and subjective distress over narcissistic hurts was less.

To illustrate this, take the case of Mrs G., who often recalled in th group her childhood wish to become a doctor. Mrs. G. often spoke of her perplexity in carying out even small household jobs and wasted a lot of her time on simple tasks like stitching old garments. She felt that she was wasting precious time and would curse herself and her fate. She would have been stitiching in the operation theatre if she had become a doctor. Hearing her lamentations, one day Mr S.N. tried to console her, but in a tune of resentment and deeper hurt than her's since he wanted to be a scholar like his father but felt that he was never given the necessary support. He consoled her with the words, 'So what if you did not become a doctor? You are now able to look after both your parents and take good medical care of your mother like a committed doctor would do. You should now buy modern aids and become self-sufficient in carrying out urine and blood tests on your bedridden mother.'

Mrs G. laughted and took these pratical tips, and told Mr S.N. that he should get a compounder to visit his own mother daily so that he had some time to devote in finding a suitable partner for himself, which he had

been postoponing for a long time. She suddenly burst into tears and said there was no happiness in nursing her aged mother since that was the duty of her father and other relatives (she meant her sister-in-law, who had set up her own household and had started working). To a certain extent Mrs G. ws correct, as she was burdened with tiresome repetitive cleaning work which infuriated her inside but no one in the family was ready to help her out. She came to group therapy and reacted with anger and pessimism, though previously she often used to express her anger by not taking baths, not cooking and eating, and behaving like a psychotic patient.

In group therapy, as Fried (1961) noted, there is greater prodcutivity and action than in individual treatment because the patient is more likely to express his feelings in reactions and actions than to report them. In group therapy even the most passive patients were found resolving their sticky dependence on the therapist and at times gave up individual and later group therapy and became 'on their own' after working through the deep-seated problems in their personalities. However, the working through process was long, laborious, tedious, and sometimes particularly unwieldly because of greater opportuniteis for acting-out behaviour. But the splitting of the transference to the therapist and projections on others in group made it more bearable for the therapist.

The feeling of satisfaction in the therapist is almost inevitably associated with the successful working through process when it seems to be taking place. The reverse happens when a patient gets into anxiety or into repetitive talk, associated with orally regressed long-suffering masochistic psychiatric individuals. The counter-transference reactions may lead to what Kubie (1968) pessimistically said about the limited resolution of transference phenomena even under the

best conditions. Kubie urges that it is essential to explore the effect of introducting extra analytic contacts between patient and analyst and of changing therapists. In the Indian setting it is better to involve the family of the psychiatric patient since they provide a better social support system.

Western psychotherapists have suggested that the therapist should consider placing the patient in group therapy towards the end of the analysis. But the dynamic quality of the reliving of painful affects as it takes place in the 'here and now' group setting seems to produce striking insights and rapid changes in behaviour shows that a combined individual and group therapy can cut down the length of effective Psychotherapy.

The mature phase at the outset

The mental health professionals' short-term closed group, called the Growth Group, was formed and set its own direction ot find out how to live with schizophrenia. The therapist had distributed a hand-out during the annual conference of clinical psychologists, and those who volunteered met for one and a half hours spread over three morning sessions. They paid a nominal membership fee and met in a closed room with the assurance of full confidentiality. The memebrs recognised quickly their barriers to movement and growth but dealt with them effectively. They could then move easily and opened up to one another. One male member was seen keeping quiet for a prolonged period but he was drawn in by another female member whose own brother was suffering from schizophrenia. She was particularly hurt inside about the stigma atached to mental illness in Indian society. She expressed her resetment over the fact that the chances of her settled marriage were doubtful. Though her brother was intelligent and idealistic, he could not cope with reality demands. This self-disclosure formed an affectionate bond between these two members

(sibling-transference), and others joined with their own observations that a schizophrenic in their experience was more socially handicapped than we so-called normal persons, who can usually resort to double morality. This growth group was full of empathetic listening, disclosure of feelings and willigness on the part of members to share personal issues (marital problems, divorce issues, family tensions etc,) candidly. The therapist had not formed this growth group with any specific goals in mind.

Concluding remarks :

Experience with various groups has made the present therapist realise that some groups begin by becoming expressive from the outset while others may be very reluctant to express feelings and may move very slowly. While there is much reliance upon the group process as being the primary force, the way the therapist composes the members of the group and conducts the therapeutic process, controlling the external variables of the analytic settings, all seem to determine the length of the group's life. In psychoanalytically oriented group therapy there is a dynamic reliving of painful affects of past life, but it takes place in the here and now group setting where multiple cross-transference, identifications and defences are enacted in an eleborate network that in the long run produces insight and change in behaviour.

Propositions of the mature phase :

1. There is a wish in the individual member to reveal one's faults to the group, but the fear of exposing oneself to attack and criticism leads to conflicts and attempts to achieve a common goal, that is to say, all are trying to get better.

2. A series of conflicts linked by distrubing motives among members constitutes the 'group culture' where group discussion is on the intellectual plane.

3. It should be understood that the therapist will be helpful and not punitive. At times negative feelings come to the surface, including in the therapist.

4. The therapy group starts with the self-oriented needs of the individual members but the therapeutic process emerges only when they become a cohesive unit (caring, sharing and doing things togther) and feel free to express felings and attitudes to socially unacceptable and tabooed subjects. The therapy group thrives on the expression of these needs and moves dynmically on its path.

5. The development of a therapy group invovles a therapeutic-alliance with the therapist, prior expectations of the patients, the nature of the group situations and the composition of the group. Certain themes keep emerging which seem to shape into common intersts and goals e.g. to provide direction or competitive feelings towards one another, fears of criticism or ridicule form peers, or threatened loss of self-esteem or family prestige. In addition, there may be a wish for a symbiotic relationship to be established with the therapist, or projection and displacement of hostil and sexual feelings towards her.

6. A single theme or several are interlinked and keep coming from to one session to another. Typically, disturbing themes are initially expressed in vague, disguised, indirect, incomplete terms, and only gradually do they become explicit and more specific. Through talk, fantasies and dream material as well as through non-verbal cues and acting-out and acing-in behaviour they become manifest. The therapist and group members must provide meaningful interpretations to the individual member. The equilibrium of group force at the close of a session influences events in the next and subsequent sessions.

7. A patient in the group may directly reveal some of hi

feelings, thoughts and urges, but mostly prefers to remain quiet. Therfore each patient plays a part in influencing the interpersonal milieu. He may by more influential at one point than at others during the long therapeutic process of group therapy. The patients are relatively unaware that their reactions contribute towards developing a collaborative process. The therapist in the mature phase should provide appropriate positive or negative reinforcement in order to promote social learning and working through and gradually prepare the successfully treated patients for termination.

8. Each patient experiences and cognitively assimilates group therapy in a highly individualised manner. His feelings of anxiety and satisfaction level may vary and his attitudes towards other patients may keep shifting according to his perception of the group's help in improving his chances of a cure and in bringing about changes in his adaptation to the outside world. Each member is ambivalent in giving up his maladaptive habits since he regards them as essential to his existence and hardships in life. Yet he also wishes to get rid of them. This may continue even after leaving individual or group psychotherapy.

9. The mature phase involves arriving at and working through solutions and increasing satisfaction among members. It consists of a group culture in which patients start feeling sufficiently comfortable to commit themselves to the group. This shared sense of commitment to the group is accompanied by a subjective feeling of relief of distress and alleviation of symptoms. In the alternative, frustration and heightened anxiety lead to an increase in symptoms and further decline in mental health.

Recommendations for Future Research

The present book written based upon the experiences in Psychoanalytically oriented psychotherapy was not only a stock-taking exercise whereby the author cum the group therapist tried to identify those variables which made it possible to run the group therapy programme uninterruptedly or to see how far she failed in carrying out which in the West has been proven to be a successful treatment. The crucial question before undertaking the investigation was how group therapy helped individual members and in what way group therapy is different from individual psychotherapy. In addition, it was also examined whether a combined treatment of individual and group psychotherapy is a better choice.

In view of the retrospective nature of reporting of the group psychotherapeutic process, the above stated questions posed cannot be fully scientifically examined. Moreover, when the sources of information were not objective and methods of research limited and unsophisticated such crucial questions are left for a well planned prospective study with a strong recommendation to plan out in future.

The previous review of literature and the clinical experiences gathered by the present group therapist suggest that the patients' perception of the curative factors and the therapist's perception (who is not unbiased or a distant experimenter) of them are not the same. Rather there will be an internally inconsistant long inventory of the curative factors. Probably in the therapy groups, the third variable namely the analytic setting could only be objectified and well controlled in carrying out a future study. It might be possible then to generalise with statistical precision how far one's observations are valid and under what set of conditions, especially when

the technique and therapists' variables are as far as possible kept constant. The patients' characteristic should be well defined in terms of inclusion and exclusion criteria. The therapist's variable may be controlled by selecting a particular school of training, since theoretical orientation and professional competence are salient factors in influencing the therapeutic process to emerge and continue in group therapy. The therapist should provide transparency (for research purposes within the scope of professional ethics) and accountability so that the group members can strengthen the group culture of loving, caring and doing things together in the group setting.

In psychoanalytic literature the therapeutic process had been well defined and investigated. Whether such process can be observed in Indian patients seems no longer an issue to be settled. But in what manner group therapeutic processes are relevant to the curative factors in our patients are crucial and therefore the present proposals made for initial phase (see page 68-70) and mature phase (see page 115-117) need to be carefully examined.

Group psychotherapy is not merely a collection of patients to be treated by a therapist/co-therapist. Rather, the therapy groups (whether led by psychoanalytically trained or therapist of any other orientaton) are relatively unstructured groups. The members assembled have higher expectations in mind from the expert mental health authority for personal help which requires therapist's constant examination of what, when, how, why questions. The members care little and are relatively ignorant about such issues. The members in group therapy join on the behest of the therapist with the conscious needs and urgency that the treatment should relieve their anxiety, distress, neurotic/psychotic disbalance. Since the therapist only has a clear perspective and knows better what impedes the therapeutic process to emerge, she is required to have a set goal to be achieved by each individual member.

Decisions that involves the basic tenets of the therapeutic process should be the responsibility of the therapist. But her focus of attention always remains the group as a whole, a living system which has inherent capacity to correct itself and the process of interaction taking place in 'here and now' to be understood in terms of conscious as well as unconscious processes: the focal-conflicts and solutions arrived by group should be viewed as of greater importance than individual psychodynamics based on psychoanalytic terminology or metapsychology.

When group forces are unleased or group pressure builds up against an individual member, the individual becomes their victim, which in psychoanalytic terminology is loss of sense of identity, loss of ego-control and emergence of id-impulses. These are threats which the group poses to individuality. In the Indian context, where rapid social changes are taking place these complex socio-dynamics at times lead to psychopathology in the vulnerable member. Here, individual psychotherapy and group psychotherapy are not antithetical, but rather are required to be combined for the benefit of an individual under stress. Even adjunct medical treatment to be given to patients by a competent physician/psychiatrist for early recovery/symptoms reduction in order to cut down sick - role giving rise to invalidism in mental diseases.

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APPENDIX

हम डाक्टर के विषय में आपकी राय जाना चाहते हैं इसलिये आप बिना किसी संकोच के तथा बिना किसी दूसरे से पूछेताछे अपनी निजी राय बतलाने की कृपा करें। आपकी राय को गुप्त (Confidential) रखा जायेगा। आप चाहें तो अपना नाम आदि भी न लिखें, लेकिन ध्यान रखें कि भाग। के अन्य प्रश्नों में आपकी उम्र, व्यवसाय आदि के बारे में लिखना जरूरी है, क्यों इसकी जानकारी हमें इस विषय के अध्ययन में मदद देगी। इसीलिये ही भाग 2 के प्रश्नों में आपके रोग और जिस डाक्टर द्वारा आपने उपचार करवाया है उसके बारे में काफी जानकारी मॉगी गई है। अच्छा होगा कि आप भाग 1, 2 के सभी प्रश्नों का उत्तर देने की कोशिश करें।

भाग 2 के प्रश्नों में डाक्टर के सम्बन्ध में कही गई 15 विशेषतायें बतलायी गयी हैं। आपको अपनी राय उन विशषताओं को, उनके महत्व के अनुसार चुनकर बतलानी हैं, ध्यान से पढ़े। आप अपने डाक्टर को किस विशेषता को पहला दर्जा या स्थान (Rating) देना चाहेंगे, उसे चुनकर, मेरे डाक्टर के आगे खाली जगह पर लिख दें और उसके सामने लिखी हुई संख्या पर अपने दर्जे का सही (✓) का निशान लगायें जैसे:–

	विशेषतायें	मेरा डाक्टर	दर्जा (Rating)
1.	दयालु	धार्मिक	1 ✓
2.	धार्मिक	लोभी	2 ✓
3.	लोभी	कठोर	3 ✓
4.	कठोर	दयालु	4 ✓

कृपया भाग 2 में लिखी गयी सभी (15) विशेषताओं को ध्यान से पढ़ने के बाद ही उनका दर्जा (Rating) निश्चित करें लेकिन बहुत अधिक सोच विचार में न उलझें।

भाग 1

नाम उम्र

लिंग स्त्री / पुरूष

शिक्षा व्यवसाय

स्थायी निवास का पता :

शादीशुदा / अन्य

भाग 2

किस तकलीफ (Complaint) के लिये आपको डाक्टर के पास

आना पड़ा है, नीचे बताये हुए ढंग से अपना जवाब लिखें :–

तकलीफ (Complaint) कितने दिनों से (Duration)	निदान या रोग का नाम (Diagnosis) यदि पता हो तो लिखें
1-	
2-	
3-	

आप अपना इलाज कहाँ करवा रहे हैं, निम्न पर सही (✓) का निशान लगायें या बतलायें :–

1- अस्पताल में भरती है। (Indoor)
2- अस्पताल के बाहरी विभाग से (Outdoor)
3- डाक्टरी दवाखाना (Private)
4- अन्य (लिखें)

आपका इलाज कैसे हो रहा है निम्न पर सही (✓) का निशान लगाकर बतलायें :–

1- मुफत (Free)
2- सरकारी अस्पताल में थोड़ी फीस देकर (Nominal fee)
3- डाक्टरों को बड़ी से बड़ी फीस देकर (Highest Charges)
4- डाक्टर के दवाखाने में फीस देकर (Private)
5- अन्य

आजकल आपका इलाज कौन कर रहा है, निम्न पर सही (✓) का निशान लगाकर बतलायें :–

1- एक विशेषज्ञ डाक्टर (Specialist)
2- कई डाक्टरों द्वारा (Senior Resident/ Student/G.P.)
3- डाक्टरी इलाज के अलावा / (Other than Allopathy)

अन्य उपचार (लिखें)

आजकल आप कैसा महसूस करते हैं, निम्न पर सही (✓) का निशान लगाकर बतलायें :–

1- बेहद बीमार
2- बीमार
3- स्वस्थ या बिल्कुल ठीक
4- अन्य (लिखें)

भाग 3 :

यहाँ पृष्ठ 1 पर लिखे गये ढंग से निम्नलिखित डाक्टर की 15 विशषताओं को उनके महत्व के अनुसार चुनकर आपको अपनी राय देनी हैं : –

संख्या No.	विशेषताएँ Qualities	मेरा डाक्टर My Doctor	दर्जा (Rating) सही का निशान लगायें
1	सबका प्यारा है Lovable		1
2	पसन्द करता/करती हूं Like him/her		2
3	स्वार्थी Selfish		3
4	गुरू Guru		4
5	पूरे भरोसे वाला Trustworthy		5
6	सच्ची माँ की तरह Like an Ideal Mother		6
7	पसन्द नहीं है Dislike him/her		7
8	आराम देने वाला Relaxing		8
9	अच्छा जीवन साथी Ideal Life partner		9

10	चतुर विद्वान Learned	10
11	गुस्सा देने वाला Provokes anger	11
12	स्पष्टवादी Frank	12
13	कामुक इच्छाओं को जगाने वाला Sexually Provokative	13
14	दुख–दर्द को समझने वाला Sympathiser	14
15	डर या उत्तेजना वाला Frightening or Emotionally upsetting	15